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ABSTRACT

The World Federation of Therapeutic Communities is an international association of drug treatment centers that use the "Therapeutic Community" (TC) to combat chemical dependency and drug addiction. Their 1985 conference focused on bridging services between the TC and the traditional human service systems. A total of 85 separate papers were presented at this conference, and in the proceedings the papers have been grouped into 10 chapters, as follows: (1) Introduction; (2) International Perspectives; (3) TC Research: State of the Art; (4) AIDS, Alcohol and Health Care; (5) Mental Health and the TC; (6) Adolescent Services and the TC; (7) Drug Abuse and the Criminal Justice System; (8) Women, Family Systems and the TC; (9) Drug Education and Prevention; and (10) Management Issues and Innovations. (NB)

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BRIDGING SERVICES

PROCEEDINGS OF THE 9TH WORLD CONFERENCE OF THERAPEUTIC COMMUNITIES

September 1-6, 1985, San Francisco, California

Edited by
Alfonso P. Acampora and Ethan Nebelkopf, M.A.
Walden House, Inc.

Drug Abuse, Human Services &
the Therapeutic Community

"Support for this project has been given by the State of California, Health and Welfare Agency, Department of Alcohol & Drug Programs."

BRIDGING SERVICES

Drug Abuse, Human Services and the Therapeutic Community

Proceedings of the 9th World Conference of Therapeutic Communities
September 1-6, 1985, San Francisco, California

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PREFACE

Ronald Reagan

President
United States of America

I am pleased to extend warm greetings to the delegates and guests gathered for the 9th International World Federation of Therapeutic Communities in San Francisco.

Nancy and I both want to take this opportunity to commend the people of San Francisco, the staff and supporters of Walden House and all those who have demonstrated their dedication to the final eradication of the problem of drug and alcohol abuse throughout this nation and the world. This kind of commitment gives us all the more hope for a realization of the goals that we share with you for this and future generations.

We also want you to know that you have our complete support and our prayers for the success of this meeting and all your future work in your noble cause. God bless you and your endeavors.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

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June 6, 1986

Mr. Alfonso P. Acampora
Chief Executive Officer
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815 Buena Vista Avenue West
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Dear Mr. Acampora:

The conference was an unqualified success that will obviously be remembered by the participants. You and your peers did an outstanding job on this prestigious and highly educational event. As Director of the California State Department of Alcohol and Drug Programs, we were pleased to have supported the Ninth World Conference of Therapeutic Communities.

The conference combined timely and interesting topics, presentations of a high quality and meaningful dialogue. Further, I found my copy of the proceedings to be highly informative and I am confident that others will feel as I do.

Again, congratulations on a job well done and best wishes to those who are planning the Tenth World Conference to be held in Sweden.

Sincerely,

Chauncey L. Veatch III

CHAUNCEY L. VEATCH III
Director

CHAPTER 1

INTRODUCTION TO THE PROCEEDINGS

WELCOME FROM THE HOST

Alfonso P. Acampora

Host Coordinator
9th World Conference of Therapeutic Communities

Chief Executive Officer
Walden House, Host Program

I would like to take this opportunity to thank the World Federation of Therapeutic Communities and the President, Monsignor William B. O'Brien, for giving me and Walden House, Inc. the great honor of hosting the 9th World Conference of Therapeutic Communities, September 1 - 6th, 1985, in San Francisco, California.

I feel that this congress was one of the best that's taken place in the United States in regards to the needs of therapeutic communities. I would also like to thank each track manager for being able to present excellent tracks that were of current interest to all of us. The sessions provided information and facts which proved valuable for all the attending delegates.

The following individuals served as managers for the tracks and each had responsibility for planning the sessions. I would like to personally thank each one of them: D. Vincent Biase (Research), David Deitch (Adolescents & Families), Ron Williams and Harry Wexler (Criminal Justice), Matthew Gissen (Management), Martien Kooyman (Mental Health), Jane Velez and Helene Gissen (Women), and Barbara Stern (Alcohol).

I would also like to take this opportunity to thank my colleagues, members of the International Organizing Committee (I.O.C.): Charles Devlin (Chairman - USA), Lars Bremberg (Sweden), Juan Corelli (Italy), Peter Vamos (Canada), and Martien Kooyman (Netherlands).

Special thanks goes to my Board of Directors: Lex Perillat, Roger Thompson, Charles Flewellen, Walter Littrell, Joan Zweben, Nello Santacroce, Kathryn Orticelle-Beaulieu and Rob Hendrickson.

I would also like to give special acknowledgement to Chester Stern, Program Developer, Debi Lowis, Fiscal Administrator, Ethan Nebelkopf, Projects Manager, John Rios, Clinical Director, Arturo Carrillo, House Manager, and Christina Acampora, Executive Secretary.

Last but not least, I would like to say I hope you had a beautiful stay in the "Beautiful City by the Bay". Please come back and see us again! With warm affection and respect I hope you enjoy reading the Proceedings of the 9th World Conference on Therapeutic Communities.

BRIDGING THE GAP: THE TC & HUMAN SERVICES

Ethan Nebelkopf, M.A.

Walden House, Inc.
San Francisco, California

Introduction to the Proceedings

The Ninth World Conference of Therapeutic Communities was held in San Francisco at the Sheraton-Palace Hotel, September 1-6, 1985, and was sponsored by the World Federation of Therapeutic Communities (WFTC), an international association of drug treatment centers utilizing the therapeutic community (TC) to combat chemical dependency and drug addiction. About 500 delegates attended from 22 nations around the world.

The idea of an international conference of TC's originated in 1975 at the International Council of Alcoholism and Addiction Congress in Bangkok, and the First World Conference of Therapeutic Communities was held in Sweden in 1976. Recent conferences have been held in Montreal (1977), New York (1979), Amsterdam (1980), Manila (1981), Chicago (1983) and Rome (1984). The Tenth World Conference is scheduled for Eskilstuna, Sweden, September 7-12, 1986.

The World Federation of Therapeutic Communities consists of delegates from about 200 countries and is guided by an Executive Council. The International Organizing Committee (IOC) is appointed by the Council and has the responsibility of planning each conference. Each year the IOC appoints a Conference Coordinator, and for the Ninth World Conference, Alfonso Acampora of Walden House in San Francisco served as host.

The theme for the Ninth World Conference, as selected by the IOC, was Bridging Services between the TC and traditional human service systems. There were ten areas designated as tracks in which presentations were made. These tracks included Research, Education/Prevention, Adolescents, Family Services, Criminal Justice, Management, Women, Mental Health, Alcohol and A.I.D.S.

The TC & Human Services

The TC emerged in the last few decades as an alternative response to the problem of drug addiction. Medicine, mental health, education, social services and the criminal justice system related to small isolated parts of the drug problem, if they related to it at all. The essential abdication of the established human service system in dealing with chemical dependency opened the way for a creative approach to the whole spectrum of problems associated with drug addiction; the therapeutic community. Today, the TC has come full circle and is becoming integrated into the traditional health care delivery network. The Ninth World Conference focused on bridging the gap between the alternative care based on the therapeutic community model and the existing human service systems in the United States and around the world.

This bridge between the therapeutic community and the health care delivery system is the common denominator among the papers which comprise the Proceedings of the Ninth World Conference of Therapeutic Communities. These proceedings constitute the state of the art in therapeutic community process, research, education and treatment. An attempt was made to codify and organize TC concepts and practices as they relate to the wider human service delivery system. The chapters of this book correspond for the most part to the tracks of the Ninth World Conference held in San Francisco, September 1-6, 1985.

International Perspectives

This chapter provides an international perspective on the therapeutic community movement as it is today. On an international level, the World Federation of Therapeutic Communities and its annual conferences provide a forum for communication and expression of innovative ideas in research and management as well as for the exploration of significant interfaces with human services in the areas of medicine, mental health, criminal justice, education and social services for adolescents and families. In addition, the World Federation serves as a focal point for the development of an international support system and extended family.

Monsignor William B. O'Brien, President of the World Federation of Therapeutic Communities began the Opening session of the Conference by describing the worldwide epidemic of drug abuse, particularly among adolescents, what the TC has to offer in fighting this disease and how the TC movement has grown internationally into a worldwide "healing family."

David Mactas, President of the Therapeutic Communities of America, portrays the development of the therapeutic community in the United States and points out areas where new ground has been broken, especially in the area of credentialing and accreditation of TC counselors. Erik Broekaert discusses the evolution of therapeutic principles in Europe as they relate to the TC and Juan Alberto Yaria speaks about how TC concepts are being applied in Latin America. Roy Johnston reports on recent developments in the Asian-Pacific region. These papers were presented in the Opening Plenary Session entitled *What's Happening on an International Level.*.

Issues regarding the future of the TC, and its relationship to the medical and mental health establishments are explored by Mitchell Rosenthal, President of Phoenix House Foundation, in a talk he gave during the Plenary Session on Mental Health. Finally, Chauncey Veatch III, Director of California's Alcohol and Drug Programs, addresses drug abuse in California and the need for joint efforts between government and providers, in the Closing Session of the Ninth World Conference.

The building of a truly multi-cultural and international support system, as reflected in the World Federation of Therapeutic Communities points out that the TC movement has much to offer traditional human services.

TC Research: State of the Art

TC research is current and timely. The Ninth World Conference served as a significant international forum for presenting state-of-the-art research concerning drug abuse. Led by D. Vincent Biase, Research Director at Daytop Village, and George De Leon, Research Director at Phoenix House, a multitude of data has been accumulated in the areas of treatment effectiveness, retention and treatment process. According to Barry Brown of the National Institute of Drug Abuse, TC researchers "have reaffirmed the integrity of the TC, and have aided all of us to retain that which is effective, and to modify that which needs change."

It has been demonstrated in outcome studies that the best indicator of success is length of time in treatment. Current research focuses on retention of clients in treatment so that we may learn more about which clients stay in programs and why clients split from treatment.

In this chapter, George De Leon presents an overview of TC research and its implications. Another promising avenue of research, pioneered by Vinnie Biase, is multi-cultural TC research, which compares and contrasts the populations, cultures and programs in different countries around the world. Also, the studies on methadone to abstinence by Alfonso Acampora and Jim Sorensen demonstrate the effectiveness and provide guidelines for methadone detoxification in a residential TC setting.

In addition, European researchers have made significant contributions. Martien Kooyman reports on a follow-up study on graduates of the Emiliehoeve TC in the Netherlands, and Luigi Cancrini presents a study of juvenile addicts and their families in Italy.

There is a wealth of valid scientific research on the therapeutic community which is comparable to research in other professional fields such as psychiatry and mental health. The Ninth World Conference highlighted research and how to apply research findings in practical ways.

A.I.D.S., Alcohol and Health Care

This chapter contains thought-provoking papers on a variety of health-related subjects, including A.I.D.S., designer drugs, cocaine, herbs and nutrition, and whether an ex-addict can drink.

A.I.D.S. is a disease which spreads rapidly among IV drug users, and is a serious health hazard facing TC's now. Don Des Jarlais of the New York Department of Substance Abuse, working closely with TC staff members, spoke in two special interest sessions on A.I.D.S., providing the latest clinical and epidemiological information on the subject.

The issue of whether an ex-addict can drink was one of the most controversial topics at the Ninth World Conference, and a Plenary Session was devoted to this issue, moderated by Barbara Stern. David E. Smith, Medical Director of the Haight-Ashbury Free Medical Clinic discussed the concept that alcoholism is a disease, and that cross addictions and substitute addictions must be examined by staff and residents of TC's. There is a risk for the ex-addict or TC graduate in taking any psychoactive substances, but all the data isn't in yet. All too often methadone becomes a substitute for heroin, and alcohol becomes a substitute for methadone.

The prevention of relapse into addiction or alcoholism is an important emerging area for further study. The TC teaches a chemical-free lifestyle. The recognition of an international support network of TC members, integrated with other self-help groups such as AA and NA can provide an effective impetus for continued personal growth and social change.

Designer drugs are also becoming a terrible health hazard. The term "designer drugs" refers to the increasing sophistication of underground chemists in manufacturing fentanyl and fentanyl- derivatives which are comparable to "synthetic heroin." Designer drugs are on the streets and they are both potent and deadly. These substances are discussed by Robbie Roberton, Chief of the Division of Drug Programs for the state of California, who presented a videotape of the effects of designer drugs at the Ninth World Conference.

To further complicate the polydrug scene, there is evidence of an epidemic of cocaine use among adults and adolescents. Cocaine has become an "in" drug among upwardly mobile professional people, but it is as addicting and debilitating as heroin or alcohol and TC's need to develop specific programs to treat cocaine addiction.

On a more positive note, there is some evidence that the overall health and immune system of addicts can be improved through nutrition and the use of herbs. One aspect of prevention is avoiding unhealthy practices, such as sharing needles. Another aspect is a positive approach in teaching individuals which foods and habits enhance personal health. The introduction of nutritional education and concepts of wellness into drug and alcohol treatment programs is an exciting new development, and several conference presentations addressed this subject.

One of the emerging trends in medicine today is a holistic approach to wellness and disease. This approach takes into account the whole person: mentally, physically and spiritually. Nutrition, physical exercise, herbs, meditation, acupuncture, stress reduction and relaxation techniques are being used more frequently as healing alternatives in TC's around the world.

Also included in this chapter is a paper written by a Walden House resident who participated in the 10 Kilometer Run for Recovery and shares his feelings about this event. Three hundred TC members participated in the Run For Recovery, which kicked off the conference and was sponsored by the California Association of Therapeutic Communities. The theme was Drug Free and Proud, emphasizing the union of body and mind.

These are all major sociomedical problems: A.I.D.S., fentanyl, alcohol, cocaine. They are having increasing impact on the TC, and we must deal with them courageously and quickly, working in conjunction with the medical establishment.

The TC, because it deals with drug addiction, necessarily interfaces against the grain of the traditional concept of the physician as the ultimate authority in manners of health. For a long time TC's co-existed with medicine; now there seems to be a move toward mutual cooperation.

Mental Health and the TC

The interface between the mental health establishment and the TC has a long and checkered history. Jerome Jaffe, Director of the National Institute of Drug Abuse, could not attend the conference at the last moment, but in his speech, which was delivered by Barry Brown, reflects on old times and new challenges in the relationship of the TC to psychiatry, and specified that "We need the old partnership to work again."

Sidney Cohen, the expert in drug research at U.C.L.A. discusses brain chemistry and endorphins, the natural pain-killers produced by the brain. Ab Koster addresses another important issue in the area of mental health which needs careful attention: where does the TC fail and what are its shortcomings?

Many clinical treatment issues, concerns and techniques are dealt with in this chapter, including medications in the TC, addict rage, minorities, gestalt therapy, art therapy, leaving the TC, the group process and multi-modality approaches. In addition, specific programs with unique populations in Brazil, Argentina, Uruguay, Finland and the U.S. are described in this chapter.

Psychiatric disorder in the TC is another crucial issue for the eighties. The concept of dual-diagnosis refers to individuals with both psychiatric problems as well as drug problems. Sherry Holland discusses the severity of psychiatric problems in the TC, and Nancy Jainchill and George De Leon report on psychiatric disturbances in TC admissions. These two papers were presented in a combined mental health/research special interest session. Dual-diagnostic individuals often decompensate under TC conditions of pressure and confrontation. They seem to benefit from the supportive and substitute family aspects of the TC, but yell at them and they bounce off walls. As with the adolescent population, the TC needs to modify some of its techniques in dealing with the borderline resident.

Adolescent Services and the TC

Teenagers are alone in our society. There exists very few positive role models in the community. More and more TC's are developing treatment programs for adolescents. This means that some TC principles and practices need to be modified in order to be effective in working with teenagers.

David Deitch presents preliminary considerations on adolescence and the TC. Charles Devlin describes how Daytop Village developed a full service adolescent program. George De Leon reports on the latest research on adolescent treatment outcomes. David Sandberg discusses the connection between child abuse and juvenile delinquency. Josefina Gallardo de Parejo discusses treatment issues in Colombia, focusing on an innovative new program for youth called Nuevo Amanecer.

Delvin Williams, former running back for the San Francisco 49'ers, describes a prevention program for teenagers in which professional athletes who have gotten off drugs serve as role models.

The TC provides an atmosphere in which adolescents can develop healthy interpersonal relationships, a value system and a chemical-free lifestyle. The children are our future. Do we want them apathetic, angry and ignorant, or can we teach them to play leadership roles in building a better planet?

Drug Abuse and the Criminal Justice System

TC's have consistently related well and worked closely with the criminal justice system to provide alternatives to incarceration for clients, and to develop effective rehabilitation for criminal addicts.

On an educational note, Lewis Yablonsky, one of the pioneer writers in the TC movement, presents a paper in which he compares the social structure and organization of the TC to that of prisons and hospitals, and summarizes several essential characteristics of the TC. He concludes that there is a qualitative difference between the TC and the form of group therapy carried on in prisons. The residents of the TC, unlike prison inmates, are involved with their own growth as well as the growth of the organization. (Actually, during the special interest session on this topic, Lew Yablonsky and Chester Stern told tall and funny tales of the old days in the TC movement).

Internationally, there is a lot of action to stop drug trafficking, and to make rational decisions on penalties for drug users. Burkhard Dammann focuses on the issue of client rights in Germany, and Guido Neppo Modona presents two alternatives for drug addicts in Italy.

Women, Family Systems and the TC

Women's issues are becoming increasingly recognized in the TC. The role of women in the family is a key aspect in any community. The difficulty that women face in climbing the executive ladder in the TC is an important issue to be dealt with. Rape, battering, incest, child abuse and the development of special groups to meet the special needs of women can no longer be ignored in the TC.

The TC works with the whole family as well as the identified patient. Substance abuse problems are reflections of family problems and family problems are compounded by substance abuse. In a total treatment picture the spouse, children, and even in some cases, the parents, of the substance abuser must be taken into account. This is not meant to mitigate the responsibility of the individual who uses drugs. Many programs are beginning to work with parents, co-dependents and children of alcoholics and substance abusers.

Shirley Colletti of the National Federation of Parents in the United States discusses her work with families. The Parents Associations at Daytop Village, Odyssey House and Walden House are described in various papers in this section. Juan Yaria and Miguel Bianucci talk about family issues in Argentina, providing an international perspective on family systems, drug abuse and society.

With the breakdown of the modern nuclear family structure, increasing divorce rates and bizarre living situations, social values are in flux and up for grabs. The extended family support system of the TC provides a safe matrix for individuals to give up drugs and develop value systems which incorporate responsibility and meaning.

The Reverend Cecil Williams of Glide Memorial Church in San Francisco gave a rousing speech during the plenary session on Parents' Associations Around the World, stated that the eighties are time for activism, and implored TC members to stop gazing at their navels and start dealing with the issues of worldwide hunger and oppression.

Drug Education and Prevention

Drug abuse is reaching epic proportions in the eighties despite 15 years of intensive drug education and prevention. The role of education in the TC is important, and education is taking a more holistic approach: academic, social, emotional, vocational, ethical and physical. Intervention efforts in the public school system have been successful in selective instances and multi-cultural educational efforts are necessary and encouraged in the TC. Often TC's are setting up private schools to provide special education for substance-abusing adolescents.

Researchers evaluating educational prevention programs over a five year period conclude that there is no magic answer to the design of an effective prevention program as reported by Silverstein and Derivan. The average age of the public schoolteacher in San Francisco is fifty-seven years old. How can they expect to reach the kids?

Management Issues and Innovations

There have been significant innovations in the management of TC's. The issue of governmental support for the TC was addressed in a major Plenary session during the conference. Lars Bremberg discusses the situation in Sweden, a welfare state, where the government provides strong support for human service programs. Richard Pruss of Samaritan House in New York, and Mimi Silbert of Delancey Street in San Francisco also speak to this issue. Delancey Street does not take government funds, and is self-supporting through the operation of several successful businesses.

How far TC's have gone from the original clinical basics in their attempt to satisfy government, industry and insurance company requirements is the subject of a paper by John Brewster and Jesse Jaramillo, who conclude that the TC is facing an identity crisis.

The use of computers in the development of management information systems for TC's was the subject of a well-attended session. Working with industry, unions, employee assistance programs and third party payors emerged as key issues in the area of management. Looking to the private sector as well as the public sector is emerging as a major future trend as we swiftly transport ourselves through the eighties.

Bridging the Gap

Although the human service delivery system is in crisis, the TC can survive if it can weave a middle course of sticking to the basics of its unique clinical approach, while administratively adopting aspects of the new technology and adapting to changing funding patterns. The current medical system is just too expensive, but TC's can utilize aspects of the medical model in developing freestanding chemical dependency recovery centers and hospitals to compete for the private dollar. Inpatient programs geared toward returning the drug-abusing employee back to work as soon as possible can co-exist in a synergistic relationship with long-term residential programs which aim at total lifestyle rehabilitation.

Similarly, adolescent programs, although for the most part residing in separate facilities than adult programs, can exist in a mutually complementary fashion with adult programs which utilize the family concept. In the same manner, inpatient and outpatient programs can work in tandem to provide aftercare services for graduates and a safe haven for the unlucky ones who slip and fall. Aftercare is a lifelong process and the support of Alcoholics Anonymous and Narcotics Anonymous can play a meaningful role in recovery. By expanding in these directions, the TC can bridge the gap and emerge as a potent contributor in the overall health care delivery service system.

The TC teaches a chemical free lifestyle. The integration, on an international level, of TC participants with other self-help groups such as AA and NA and with ties to established medical, mental health, educational and criminal justice institutions is becoming a reality in the not too distant future.

The media has taken over the transmission of social values from the family. Glamour, money, status, pseudo-sex and supercharged turbos have replaced friendship, belonging, honesty, and human dignity as important goals to strive for. The TC replicates the family of the drug abuser with a mini-community, and then encourages the individual, during re-entry, to deal with his or her own family in healthier and more creative ways. Sometimes it means reunion, other times, separation. Such is the nature of life and death.

The Ninth World Conference reflected an intricate spiderweb of inter-relationships and sub-networks. It was a great conference. The emotions ran deep and the stimulation was intense. The conference topics covered a broad spectrum of human knowledge. A cornerstone was placed in the foundation of synergistic bridges between the TC and the traditional human services.

Someone wrote on the bulletin board of the conference staff office at the Sheraton-Palace, "If you have a need, please leave a message on the board and hope someone will respond." More often than not someone responded. This summarized for me the feeling of the conference.

A little after the conference, a humpback whale crossed under the Golden Gate Bridge into San Francisco Bay, and swam up the Sacramento River. Humphrey the Humpback Whale was "lost" for 28 days. Human researchers observed the whale while the whale sized up the people. We couldn't tell if Humphrey was a he or she, if he was sick, lost, brain-damaged, high on drugs, pregnant or just plain curious.

God knows what Humphrey thought of the humans. I think that Humphrey was a messenger from the whale community, our marine mammal cousins. He wanted to make contact, maybe to send out some feelers about establishing a summit meeting between the whales and the humans. The only problem was that he was a dollar short and a day late for the Ninth World Conference.

OFFICE OF THE MAYOR
SAN FRANCISCO

DIANNE FEINSTEIN

World Federation of Therapeutic Communities
c/o Walden House, Inc.
San Francisco, CA 94117

Dear Friends:

I am very pleased to convey San Francisco's heartfelt Welcome and warmest Best Wishes to everyone participating in the 9th Conference of the World Federation of Therapeutic Communities, which is being held here in our City from September 1-6, 1985.

We certainly hope that all of you attending this important meeting will get beyond its exciting sessions and visit our City for a first-hand look at what we believe is one of the world's most dynamic and exciting cities. It is a city justly renowned for its spectacular scenery and for its richly diverse, cosmopolitan communities.

San Francisco takes great pride in being a gateway to the Pacific, the technological, financial and service center of the great American West, and a city where residents nurture mutual respect of others. We care deeply about preserving our environmental and historical heritage--and we look forward to sharing with you a bundle of treasures like our unique Cable Cars, the splendid Golden Gate Bridge, fabulous views of the world's most beautiful Bay and the incomparable Golden Gate Park.

Please know that your distinguished participants are enthusiastically welcome in our City, and be assured that we will do everything possible to make your time in San Francisco both memorable and enjoyable.

Have a wonderful visit and please come back just as soon and as often as you can.

Warm personal regards,

Sincerely,

DIANNE FEINSTEIN
MAYOR

DF/ws

CHAPTER 2

INTERNATIONAL PERSPECTIVES

WHAT'S HAPPENING ON AN INTERNATIONAL LEVEL

Msgr. William B. O'Brien

President
World Federation of Therapeutic Communities

Let me first say it is good to be here in San Francisco at the Ninth World Conference of Therapeutic Communities.

As I stand before you this morning and look out on this most impressive and esteemed audience, I can't help thinking about the man who was killed in a recent flash flood. He made his way to heaven, and at the Pearly Gates he was asked to give his case history, to tell the story of how he died and came to heaven. This he obligingly did. St. Peter thought the story so interesting that he asked the new arrival if he would agree to give a seminar for the other angels in heaven, telling them all about the flood and his demise.

The newly arrived resident of heaven was very much flattered and he immediately accepted the invitation to tell all about the flood. As he flew away to prepare for his talk on this devastating flood, a kind young angel tugged at the sleeve of his robe and said, "Sir, I think there's something I ought to tell you. When you give the seminar on the flood, Noah will be in the audience."

My point is that I'm somewhat disconcerted at being up here talking before such an imposing group of experts in the field as yourselves--all of you Noahs, so to speak! But that is what makes a World Conference of Therapeutic Communities so stimulating: the fact that it attracts the leaders in the field from around the world and provides a forum where ideas, knowledge, and the latest research can be shared and discussed as we steadfastly endeavor to refine our skills.

I would like to take time now to express my sincere gratitude and appreciation to Alfonso Acampora, Executive Director of our host program, Walden House, who has done a truly outstanding job of organizing this conference. It has been well documented that in the history of San Francisco there have been two major turning points: one was the Great Earthquake of 1906 and the other was the arrival of Alfonso Acampora from New York. To this day there is still heated discussion as to which event holds greater significance. But there is no doubt in our minds. We know it was Alfonso's arrival, and San Francisco has never been quite the same since.

For many years following the Great Earthquake the people of the Bay Area would date their lives from "before the earthquake" or "after the earthquake." Well, I am certain that this Ninth World Conference, under the leadership of Alfonso, will also have tremendous impact, but a very positive one. Its tremors will be felt around the world as, years from now, in looking back on the therapeutic community movement, we will date it from "before the Ninth World Conference" or "after the Ninth World conference."

Seeing so many friends and respected colleagues who have traveled great distances to be here gives one a feeling of great joy and satisfaction. As members of the therapeutic community movement, we are in many ways an extended family. In this spirit, and on behalf of the World Federation of Therapeutic Communities, I would like to welcome you to our ninth annual family reunion. As with most family reunions, God knows, we have our share of differences. But this is healthy, as we share ideas and feelings in the open and honest atmosphere unique to the therapeutic community. Our family ties are strong and responsive to the needs of our members, and this portends well for the future of the movement.

As we gather here in San Francisco at the foot of the Golden Gate Bridge, on the eve of its 50th anniversary, it is fitting that the theme of this Ninth World Conference is Bridging Services. When the Golden Gate bridge was completed in 1937, no body of water as wide or as deep as that strait had ever before been bridged. To be contended with were the physical problems of stretching a span across a deep four-mile wide body of water with treacherous currents in a region subject to high winds and possible earthquakes. After nearly five decades this bridge remains one of the world's greatest engineering achievements.

No less remarkable than the bridge itself were the men who designed it. Single mindedly they struggled against vested interests, interference from government departments, insufficient funds, shoddy workmanship, corruption, ignorance, and more than anything, the enormous technical problems of the crossing itself, risking their health and wearing themselves out. It sounds an awful lot like the struggles of today's therapeutic community directors, doesn't it?

Similar to the engineers and builders of the Golden Gate Bridge, we in the therapeutic community movement today are faced with the challenge of constructing a bridge between services and effectively spanning the treacherous currents and rising tides of substance abuse and despair which threaten to engulf our young--our most precious resource. Indeed, whether it's the streets of San Francisco, California or the back roads of Sao Paolo, Brazil, in cities and countries around the world, in tragic and unrelenting fashion, we are losing our children to substance abuse.

We continually read reports of increased substance abuse, rising teenage suicides, pervasive despair and alienation. The only decline reported in substance abuse in recent years has been in the age of the victims. In ever more increasing numbers youngsters are entering our treatment programs as young as 9 and 10 years of age. It is clear the substance abuse has become an insidious threat to our young around the world. In Italy, Ireland, Brazil, Argentina, Sweden, the Asian Pacific Region and countries around the glove, the recurring theme focuses on the plight of our young caught in the vortex of substance abuse swirling through our societies. In the United States, the Surgeon General recently reported that since 1905 American life expectancy has improved for every age category except one: 15 to 24 year olds. The death rate among this group has actually increased over the last twenty years, primarily due to substance abuse. The extent to which our youth are abusing substances is staggering. The highest drug use rate is among 18 to 25 year olds, and 12 to 17 year olds have the second highest rate. Reports have cited children as young as 9 and 10 saving their lunch money to buy a wide variety of drugs that are as accessible on street corners as ice cream and candy. This is not unique to the United States, however. It is seen throughout the world.

The present scourge of drug abuse is now compounded by the brutal fact that the incidence of AIDS (Acquired Immune Deficiency Syndrome) among intravenous drug abusers has been growing geometrically in recent months. Indeed, this group will soon surpass homosexuals as being most at risk to contract this deadly disease. In New York, for example, AIDS is now the second leading cause of death for women between the age of 30 and 34. These female AIDS victims are all either drug abusers or have had sexual contact with drug users.

It is clear that substance abuse is eating away at the very essence of our societies--the family. It is not merely a chemical problem, but a deeply human crisis. The therapeutic community is in the unique position to examine the mental and emotional forces that are shaping young lives around the world and plan appropriate intervention. Our children are yearning for a sense of direction and the therapeutic community is singularly qualified to provide it.

There is no doubt that the therapeutic community is one of the most potent treatment modalities in helping individuals achieve change. The elimination of the symptom, be it substance abuse or other disorders, is only part of the treatment and help. We achieve change as a result of meeting the needs of individuals by providing the necessary services. The greatest need is a sense of community, a sense of belonging, and this is what the therapeutic community provides as it effectively deals with the pains of modern man-loneliness and alienation. The key, then, is that the therapeutic community deals with root causes rather than merely treating symptoms.

As President of the World Federation of Therapeutic Communities, I have traveled extensively around the world visiting program, and I am pleased to report that I was reassured by what I saw. One cannot help but be deeply impressed by the basic strength of our movement. That strength is reflected in the individual programs, in their dynamic development and, above all, in their dedicated staff.

In people like Lars Bremberg and the outstanding job he and his lovely bride, Helena, are doing in leading the TC movement in Scandinavia. In Sweden alone, Vallmotorp and Daytop, the two sister foundations, have a total of 300 beds located in seven different houses and are still expanding. A short-term treatment program will be opening in October, and Lars is now overseeing the training and development of TC staff in Thailand.

In the Pacific, Roy Johnston has been tirelessly and generously working on behalf of the TC movement as President of the recently established Asian/Pacific Federation of Therapeutic Communities.

In Ireland, we have seen the growth and expansion of Coolemine under the leadership of Jim Comberton and Tom McGarry. Our congratulations also go to Jim on his recent election to the Presidency of the European Federation of Therapeutic Communities.

In England, Phoenix House, under the creative leadership of David Tomlinson, now has centers across Great Britain offering 150 treatment beds with age range of 18 to 25 years. They were recently honored by a visit from Prince Charles.

In Italy, the programs of Il Centro Di Solidarieta continue to thrive and flourish under the dedicated leadership of Don Mario Picchi and Juan Corelli. In October there will be the formal dedication of their new center in Rome. In northern Italy we have witnessed the miracle of Avanzini! Msgr. Avanzini has done a truly remarkable job in developing and directing a thriving, vital TC in Verona. He recently acquired an abandoned airport, and on this site he will soon be opening what has been described as a modern day "boys town." The World Federation can now boast its very own "Father Flanagan!" Fortunate indeed are the young boys and girls of Verona.

In South America, through the dedicated work of Juan Alberto Yaria and Miguel Angel Bianucci of Argentina, the Latin American Federation of Therapeutic Communities was recently created, and this bodes well for the movement.

Under the expert guidance of Peter Vamos, Portage has experienced tremendous growth and is Canada's largest drug-free treatment program.

Here in the United States, the Therapeutic Communities of America has thrived and reached new heights of achievement under the leadership of its President, David Mactas. Its member programs throughout this country are setting a new standard of excellence which makes us all very proud.

I apologize that, due to obvious time constraints, I have been able to name but a few of the many individuals and programs generously giving of themselves and contributing so much to the therapeutic community movement. I wish I had more time to name all of you, but you know who you are. And so, to all of you, for recognizing the problems as well as the potential with which we are faced, I salute you.

At this time I would also like to make a special salute to our dear friend and respected colleague, Harry Sholl, who recently passed away after a long illness. As Co-founder and President of Gateway House Foundation in Chicago, Harry guided that program to international prominence. He was responsible for the establishment of Therapeutic Communities of America and served as the founding President. Harry was also Co-founder and Treasurer of the World Federation of Therapeutic Communities. Harry, like no other man, attracted and engaged the love, affection, and respect of all of us. He awakened in each of us a sense of dedication, love and excellence that we will always treasure. Full of wisdom, wit and a great sense of humor, Harry was a generous and loving man, a true humanist who will remain a shining example for all of us.

The therapeutic community movement is now on the threshold of a new era. We have the global membership essential for a global approach to substance abuse and related disorders. We must not fail to play our roles effectively. As the theme of this Ninth World Conference indicates, the role of the therapeutic community should be bridging services. Let us make the therapeutic community the bridge that connects the community, the authorities, the professionals, the law, the families and the addict himself. As a bridge, the therapeutic community can bring people closer together and facilitate movement and development by shortening distances and crossing barriers to communication. As with a bridge, the therapeutic community can represent the perfect blending of science and art as it spans the troubled waters of despair, isolation and alienation and leads the way
to the much sought after love, support, fraternal concern and, indeed, family where one can grow and flourish. As the bridge leads to the discovery of new lands, the TC, as stated by Pope John Paul II at last year's conference, can "lead to the discovery of human dignity."

Today governments around the world continue to be content with the question, "What?" in terms of the youth equation, "What drugs? What crime?" and answer with simplistic but politically attractive responses to this complex issue. The therapeutic community or "healing family" speaks to the all-important question, "Why? Why do you take drugs? Why do you act irresponsibly?" It thereby moves the central focus from symptom to root cause, from the drug to the person opting for the drug, and from the crime to the person electing to violate society's code.

It is to this causal "why?" of substance abuse that we as treatment leaders should address ourselves this week in a concerted effort to initiate programs of meaningful action for all concerned. I look forward in the days ahead to discussing this question with you as we share our views and mutual concerns. Let us use this

Ninth World Conference as the opportunity to build the bridges that will conquer the void of despair and loneliness, and bring order out of chaos. Let it be the bridge that will facilitate communication where we all can learn and grow and come away with new ideas.

As the "healing family," the therapeutic community has the healing power to foster the transformation of our lost, alienated youth into responsible, caring, productive individuals impelled to help others find the same happiness. It is in the therapeutic community that a true revolution of the spirit takes place, and we must never lose this. Rather than being discouraged by substance abuse and related disorders of our young, we have the opportunity to accept the challenge it presents. as our host program for this conference is Walden House, it seems only fitting to recall the words of Henry David Thoreau in Walden, "If one advances confidently in the direction of his ideas, and endeavors to live the life which he has imagines, he will meet with a success unexpected in common hours." With this in mind, together this week, let us advance in the direction of our dreams in our quest for a relevant, dynamic and vital TC.

Let our time together be the time of improvement. Let us promote the concept of the therapeutic community and develop the resources of our programs throughout the world. Let us work together in the spirit of union, harmony and, indeed, love as we become the builders of bridges between man and his potential and span new heights and breadths in the historic and ongoing journey of the TC movement.

THERAPEUTIC COMMUNITIES OF AMERICA

David J. Mactas

President
Therapeutic Communities of America

The Ninth World Conference of Therapeutic Communities will be a memorable event. It is another chapter in the evolution of the therapeutic community. The tradition has been set.

That the TC movement continues to gain impetus is owed not only to the effectiveness of the model. Tenure, as well, is a most significant variable. As programs approach the 20 year milestone, so, too, do legions of treatment professionals. The opportunity to work in so dynamic an environment, and collaborate with residents toward maximization of human potential, fuels staff enthusiasm while affirming the TC as an exciting and uplifting career choice.

At the time of the First World Conference in Sweden, many of us in the U.S. were bound by a common agenda--survival. Today, given a foundation built on success, our agendas are testimony to diversity and sophistication. However, as we continue to carve our niche in the human service arena, we are often called upon to summon the strength derived from struggles past. While we enjoy more pervasive acceptance, "complacency" is a word not found in our glossary. We are innovative and resourceful, yet adaptive and accountable.

In light of the diversity of TCA member agencies, it is indeed difficult to assess the "state of the art." So many of us have applied our expertise to new areas and have dramatically expanded our repertoire. Perhaps therein lies a common thread--the incorporation of new constituencies into our continuum of services.

Among those "new" groups served are impaired physicians, those convicted of driving while intoxicated, and substance abusers in the work setting. The development of such programs is testimony to a growing acknowledgment that our agencies have been underutilized resources. Growth and development in such pursuits serve to strengthen our status in the human service arena. Moreover, with such sophistication comes greater understanding and acceptance for our primary focus--the therapeutic community.

We have learned that sound business management principles and humane administration are not mutually exclusive. Rather, they are complementary. A not-for-profit designation does not suggest that expenses must exceed revenues. A growing fund balance helps to insure organizational stability, not necessarily the trappings of the profit motive.

Enhancement of the TC lexicon reflects development. Investment strategies, property management and computer technology are among those areas with which we have become increasingly concerned. Such concepts and language augment, rather than replace, that which is traditional and functional in the TC. Greater confidence in the efficacy of the TC model has created a less insular contingent of professionals which recognized alternative resources. It should be noted that this trend can be seen in our respective staffing patterns and roster of consultants. Such development, it is suggested, poses no threat to the character, integrity, spirit or effectiveness of the TC. It is built on the bedrock of a humane and exciting model responsible for the reclamation of countless lives.

The TCA credentialing and accreditation process has certified almost 200 direct care staff as of this writing. Nationally acclaimed for its comprehensiveness, this initiative acknowledges professionalism and competence while reinforcing a sense of community among colleagues throughout North America.

This Ninth World Conference affords a global perspective. It is an opportunity to embrace old friends, make new friends, and to celebrate the memories of those who have passed in body, but whose spirits fuel our continued commitment.

Harry Sholl, TCA's founding president, is no longer with us. However, all of us who were privileged to know him will be forever buoyed by the inspiration he instilled. The entire TC community, world wide, has been touched by his deeds and goodness. We all mourn his loss.

That San Francisco is the present venue for our conference is of particular interest. Devastated by the earthquake and fire of 1906, it is a city which, consistent with the self-help concept, recognized its capacity to heal its own wounds and rose again to regain its splendor, its uniqueness and its character. It is, to be sure, an environment conducive to personal growth and enlightenment.

On behalf of Therapeutic Communities of America, I am honored to welcome our good friends and colleagues. As in years past, I am confident that our week together will be fun, informative, and, ultimately, will serve to re-affirm our sense of mission.

TCA NEWS

Spring, 1986 THERAPEUTIC COMMUNITIES of AMERICA Vol. 7, No. 2

TCA PRESIDENT TESTIFIES IN WASHINGTON

TCA President David Mactas, accompanied by Richard Pruss, chairman of TCA's Federal Oversight Task Force, attended a hearing before the U.S. House of Representatives Subcommittee on Crime of the Committee of the Judiciary on H.R. 526 and H.R. 2954, relating to Narcotics Assistance and Controlled Substances Penalties, held in Washington, D.C., on March 13.

In testimony presented to the Subcommittee, Mactas reminded the members that substance abuse problems persist and that in 1984, according to Attorney General Edwin Meese, "... there was an increase in the illicit use of all dangerous drugs," while appropriations for treatment continue to shrink.

Stressing the economy and efficacy of the therapeutic community, the difficulties arising from increased cost of treatment, the need for additional programs for adolescents and the elderly, and the high incidence of AIDS among intravenous drug abusers, Mactas' testimony in support of H.R. 526 praised the Rangel bill as an "important piece of legislation ... (that) represents great scholarship, insight and sensitivity."

"There has long been a sense of competition between those who enforce and those who treat—as if we're fighting different enemies," Mactas said. "H.R. 526 ... at last proposes a collaboration ... (and) would authorize federal funds for 1986-1990 to assist the states, based upon the extent of the drug problem."

HOST AGENCY:
ABRAXAS

The Abraxas Foundation is pleased to welcome the TCA membership to America's Number One City. According to Rand-McNally's *Places Rated Almanac*, Pittsburgh tops the list of the nation's "most livable" cities. We are proud that Abraxas, as one of many fine human service agencies in this area, has played a part in enhancing the quality of life for over two million residents of the Pittsburgh region.

Abraxas is a private, nonprofit corporation, with a history that goes back to 1973 when juvenile and adult courts in Pennsylvania were struggling with the dilemma of rapidly increasing numbers of young drug and alcohol offenders.

A remote woodland site, a former Civilian Conservation Corps camp in the 1930s and Job Corps Center in the 1960s, was identified as a place where a treatment center could be developed to serve as an alternative to incarceration. A proposal was submitted and accepted and a program was launched as a pilot project of the Governor's Council on Drug and Alcohol Abuse (now the Office of Drug and Alcohol Programs of the Pennsylvania Department of Health). It was the only such project in the state; and Abraxas continues to be the only private agency to receive direct state support, a very small part now of our overall budget.

Supported primarily by fee-for-service contracts with the courts and child welfare agencies, and with the additional support of private sector donors who help to subsidize our costs and enable us to keep our fees low and therefore attractive to financially hard-pressed county agencies, Abraxas has grown and expanded over the years and currently offers a wide range of substance abuse treatment and rehabilitation services.

New Abraxas Dorm

HISTORICAL INFLUENCES AND EVOLUTION OF CURRENT THERAPEUTICS IN EUROPE

Dr. Erik Broekaert and Catherine Rooryck, M.A.

European Federation of Therapeutic Communities
Gent, Belgium

To understand the essence of the present day European therapeutic communities, one has to start from a historical perspective on the treatment of people with problems. History shows how an evolution took place in psychiatric institutions from religious inspired care to a medical-scientific approach. Later on, the human reactions against psychiatry led to the development of the TC.

During previous conferences, lecturers frequently referred to relations between TCs and the early Christian concept. Mowrer (1) discussed how the intrinsic value of the Christian faith was transferred during group meetings where the members publicly confessed to release themselves from guilt. This process was called exomologesis. This Christian-Jewish tradition and its influence by Hellenism was brought to Europe by Arabs via Byzantium and Spain. Studious monks investigated the old texts in the scriptoria of their monasteries. Through their exegesis, they prepared the way for the flourishing of the Catholic Church. This exegesis tried to better understand God, and the deeper, worthy nature of things. Exaggerated politicizing of the religious life in the 17th century led to a rising protestantism that wanted to draw on early Christian experience. This caused violent reactions. Although Catholic orders, such as the one of Vincentius a Paulo, tried to ameliorate the fate of people, protestant reactions arose in the bosom of the church. It is known how Quakers and the Swiss reformed church (Zwingli), were of great impact on the development of the TC (2). The Swiss reformed church served as a source of inspiration for the Buchmann and Oxford groups (3), which prepared the movement of Alcoholics Anonymous, and later Synanon (4). The Quakers prepared for the medical evolution in psychiatry. It is no secret that the "moral treatment" started with Dr. Tuke (5), who was inspired by the Great founders of his movement: William Penn and Margaret Fall (6). In Cunningham, England, they started the humane treatment of prisoners, adults and children incarcerated in the deepest jails.

Through Dr. Tuke, this "moral treatment" influenced the great French psychiatrist Pinel (7) who, in La Salpetriere in Paris, unchained the psychiatric patients. He served as an example to the famous psychiatrist of Ghent, Dr. Guislain (8), whose institution became a model of humane psychiatric care in Europe. These Quakers left England for Philadelphia. There is a connection between "the guidance" they experienced during their prayers and the present known therapeutic methods.

France became the center of the scientific world, and 19th century science expanded. It is remarkable how this scientific interference led to the finding of a close attachment between the care for adult and young handicapped people and the problems of the psychiatric patient. After the revolutionary work in La Salpetrier, Pinel had an astonishing influence on Dr. Itard (9), who was looking for an appropriate education for "the Wild Boy of Aveyron," found naked in the woods. Science tried to resolve the problem whether he was mentally disturbed, deaf, or socially neglected, since he couldn't speak, read or write, walked on hands and feet and uttered bestial sounds. In this scientific approach, Itaard associated with Abbe de L'Epee (10), who developed the sign language for deaf mutes. "The Wild Boy of Aveyron" was treated with the method for the deaf, and a close connection between problems of children with handicaps and the totality of the social life was proven. Itard's disciple Seguin (11) took a revolutionary position. He considered idiocy as a developmental disturbance and thus treatable. The mentally handicapped were considered as having a typical way of being. They could be developed through work, dedication and understanding.

This way of thinking led to an optimistic scientific view on the possibilities of treatment. This scientific evolution in Europe was further inspired by Freud (12), who was a neurologist and a disciple of Charcot (13). Freud was well informed on French psychiatry. Starting from a materialistic-scientific point of view, he discovered the importance of the intra-psychic component. He was strongly influenced by hypnosis and mesmerism. Like the Essenes and Christ, Freud was also of Jewish origin. Freud's disciple Jung (14) broadened the revolutionary heads of Freud with the universal-symbolic component. He denied dualism and looked for the unity within contradiction as the essence of treatment. Because of World War II, European psychiatrists and educators, well aware of the psychoanalytical theories, fled to the United States. There they laid the foundation of the existential-humanistic psychology. Out of their reaction against the medicated psychiatric hospital, the TC movement grew.

All this led to some remarkable present day tendencies within the European TC:

- Analytical psychotherapy lacks structuralizing influences. For this reason affiliation to a more social-educational way of handling predominates. Living together becomes the starting point of moral consciousness. Conflicts which rise in daily life situations form the basis of therapeutic encounter.

- Social life has to contend with serious economic problems. These go hand in hand with the multi-nationalizing of concerns. All this leads to a conservative-liberal policy and a tendency for "survival of the fittest." In the social sector innovative solutions are designed to combine creativity and cost effectiveness.

- The uncertainty involving the struggle for life leads to a tendency of sectarianism and radicalizing of minority groups. The lack of personal security is replaced by the certainty of the guru, in whose warm hands one can experience the security of love, or by politically engaged action groups.

- Because of the socio-economic decline, the inhabitants of the TC become materially more neglected and aggressive. Consequently, the treatment becomes more disciplined and profound. This gives a chance to realize the revolutionary TC ideology through school and education.

Summarizing, we can say that therapies in Europe are becoming replaced by educational action which stresses human individuality. The client or resident is considered as part of a dynamic family. This move towards restoring values also finds its reflection in the social structure. They become more conservative and postulate the struggle for life. Certainty is looked for in small minority groups of sectarian or political nature. All this is reflected with scientific research which switches from an objective to an engaged subjective approach. Maybe the solution lies in the humanistic expedition of Tijl Uilenspiegel who continually amazes the world by his fight for freedom and creative solution (16).

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THE THERAPEUTIC COMMUNITY IN LATIN AMERICA

Dr. Juan Alberto Yaria

Gradiva Therapeutic Community
Buenos Aires, Argentina

Gradiva Therapeutic Community was born in Buenos Aires, Argentina in 1972 as a new and different approach to solve psychiatric and psychological problems. Institutional psychiatry in our country has usually been very strong, so our project was not very warmly welcomed as there was some distrust and skepticism. Besides, our name had to be changed under the 1976-1983 political regime. During that period our facility was not a therapeutic community but a psychiatric clinic, otherwise the government would have closed the premises. Anyway, community therapy was practiced inside. There is no doubt these res trictions reduced our possibilities of development, though thanks to the 1984 Rome Congress a more dynamic drive was introduced.

This is a pathognomonic fact of what happened to the therapeutic community in Argentina and still is happening in many parts of South America. A proper analysis of our development should include historical circumstances of our peoples and their leadership, both in the political and medical fields where there is reluctance to accept changes as proposed by the therapeutic community.

However, our task was fulfilled. College support movements were created at Universidad del Salvador and Universidad de Belgrano. Assistance was given to new therapeutic communities in other Argentine cities (Rosario, Tucuman, Jujuy) and South American nations (Uruguay, Peru, Brazil, Bolivia and Paraguay).

After 13 years we feel our experience, our ideas and our particular views on the therapeutic community should be shared. The presence of Brian Madden, Charles Devlin, H. Gissen and A. Acampora last June has been a very positive contribution which we deeply appreciate. We believe we deserve some credit for the long way we had to come in our attempt to devise a therapeutic praxis. There is a background. In the same way as one person's name shows his or her parents' choice, the name Gradiva bears the trademark of S. Freud. Not the Freud you criticize, but the Freud we understand. He who teaches us that it is through language than an individual's problem should be deciphered. For us this involves family language, as he who comes to us is subject to family power, be it because of excess or shortage of such power.

Power with a victim, and at the same time a victim who supplements the victimizer, playing the role assigned by the latter. This is the major problem of he who comes to the consulting room. As a paradox, the victimizer is also a victim of the other.

Gradiva, a work by Freud we have taken up as our emblem and badge, outlines different areas suitable for an approach to the therapeutic community.

Language Analysis

From this standpoint, the therapeutic community is an area for symbolization of conflicts in a family group the outcome of which is the consulting person. An area for symbolization means that all the group activities are connected by an axis, which is dialogue. The subject is exposed to confrontation, but a confrontation where intersubject sanctions are the key. Resorting to dialogue (etymologically the link between language and reason) is tantamount to reviving the ancient Socratic method where questioning leads to truth.

The therapeutic community as an area for symbolization has a very deep meaning for us, as it involves not only a broad theoretical background based upon L. Strauss" structuralism and modern linguistic theory from Saussure to Chomsky, but also because the whole community can be defined as a "symbolic organization" where all members take part every day in "symbolic rituals" which make therapeutic culture and tradition. Gatherings and meetings of different character, groups seeking a varied scope of goals; but the most important aspect is "listening and dialogue," the foundations of the whole work.

The ancient Greeks have taught us that human problems are solved, brought over to awareness, or tolerated by speaking them out. Language was for them immanent and transcendental at the same time, emerging from subjectivity, belonging to no one. It is what modern linguistics calls the place of the Other (of everyone and no one). It is in dialogue that different interaction parties will find their borders. Language draws the line dividing what is possible from what is impossible. Omnipotence yields ground in favor of intersubject sanction and confrontation.

Symbolizing every human relation in the community gradually enables the subject, without his becoming aware of it, to be different, regarding himself, the others and the environment. From this standpoint the therapeutic achievement would be being different, being capable of being different. This differentiation, as already stated, would be gradual, coming in three stages which serve as the basis for growth:

- sexual differentiation (awareness of a sex)
- generational differentiation (overcoming sick dependence on parents and designing a vital project)
- social identity-founding differentiation (the field of concrete social praxis).

The participation democracy emphasized by M. Jones is for us the application of language. Dissent, conflict and ensuing results, confrontation and interpretation are stages as a consequence of the symbolic "machinery" which makes a man a man.

We are different from behavioral therapeutic communities. Language brings us closer to a subject's history; he will have to find out--if he is willing to--his place in that history, and its connection with parents' history.

We are different from projects of therapeutic community resorting only to the subject's will and behavioral reformation. We believe that these are only good intentions ignoring the deep and complex fabrics of a person's disorders.

In a therapeutic community truth can be made more or less evident through language. Quoting the ancient Greeks in this sense, truth is alethea, that is, permanent questioning. Different sets of activities and elaboration beyond factual activities create links for permanent questioning. It is with the Other that I get involved; or whom I fight: it is through the Other that I ask myself questions.

A therapeutic community must create the framework suitable for questioning. Those who come to the therapeutic community do so conveying full responses (e.g. a closed omnipotence posed by addicts); task groups will bring the subject within the scope of questioning. In the end, behind his human problem the question will stand, "Who am I as a person?" This question will put man closer to his being, which in turn can only be conquered from the "listening to" as posed by Martin Heidegger. Listening and questioning become the media conveying a history which makes sense, where a solid project will be built. The institutional staff is the ground where listening and questioning will first become the foundation for a sound therapeutic project. The whole community participates in a joint task which I called the field of "symbolic efficiency" in a 1982 book, *Psychotherapeutic Approach to Psychosis*. "a passage from thing to symbol and from symbol to symbol." Such a path involves a discovery to get rid of the limited scope of literate and concrete matters, to be able to travel across a new dimension of meaning, questioning what has happened. Restoring symbolic capabilities--that is what is secured. The actual freedom and independence comes from differentiation, passing from dependent immediacy to mediation through the long road of symbolization where community mates are the agents.

The community is a framework for symbolization where a democratic environment produces every signal processed within; the community framework and the group rules will bring the symbolization goals closer. In a non-democratic environment deprived of rules, and without a proper framework nothing can have a meaning. A therapeutic community can only be significant for itself as well as for its members provided it creates the suitable framework for double sense-to be able to approach reality as an equivocal entity doing away with the slavery resulting from the viewpoint that considers reality as unequivocal. An organic framework makes it possible to achieve double sense; so the therapeutic community can be described as the restoration of a living dialogue within a legal framework. Stemming from such a legal and legitimate context, dialogue yields positive results.

The therapeutic community itself is a social criticism, giving priority to dialogue as opposed to narcissistic microsubjects posed by social forces. It gives priority to the binding capacity of meaning, listening and questioning, against the purest answers of mass culture. It generates links and relations where equivocal elements develop against unequivocal lecturing by the Master.

The Therapeutic Community as Family Environment

For us the disturbed individual is a mockery of alienating family life. It is a distorted portrait. The truth appears absurd, since truth can be shown through absurdity. The identified patientis showing what others cannot see of themselves, their truth as in a negative film. His human problem is made in the family. He becomes a scapegoat of a significant relationship pattern and at the same time is an observer of that pattern, expressing them all and protecting them all so no one could penetrate that pattern.

He is a product of several generations of conflict, finding it symbolization in him. Varying interface effects of characters and roles can be observed in family life. Up to a certain extent characters play a role which imposes restrictions on subjectivity, as in the case of father or mother roles. We often observe parents deserting their roles, posing the question of parenthood and its awareness. This brings about the masculine-feminine elements and the question of characters unable to take up human-supporting roles in technological society families.

This is paramount in the case of the character of the father and his relation to the role of father in cases of addiction. Tracing two etymological origins of the term family we find: a) famulus, group of slaves, offspring and servants to a Master; b) a femore, linked to a structure, to an order, as for the ancient femur was an indication of physical order of the body. This two-fold dimension of family poses two assets showing at the consulting room: one the one hand, all-embracing power where the disturbed individual is a clearcut example of pathological slavery; on the other hand, the structural condition of a subject. No human relationship will ever occur where there is no family. Our therapeutic community is a family community. For Gradiva, family is a part of a three-stage therapeutic process:

- a primary-group gathering
- a multi-family gathering, and at the same time
- active participation in institutional therapeutic moments.

The Therapeutic Community as a Criticism to Power

We see power as a narcissistic structure contrary to the proper use of authority as proposed by the therapeutic community, which implies group operation based upon the Law, parting with a notion of power concentrated in one hand. Authority is a result of a covenant. Narcissistic power is based on bribery and obedience to avoid dying or going insane.

Pinel setting madmen free, Freud releasing neurotics from the prison of the unconscious, and above all, M. Jones showing traditional medical power brutality connected to institutions operating as prison camps. After that Bateson bringing a twin-link as a power combination by a victim and victimizer. From that imaginary "prison camp" picking the mother-child relation as a model--though it could be applicable to any human relation where contradiction occurs--the only way out is counter-violence, or else meta-communication. The twin-link acts as a narcissistic trap where symbolization fails to offer a way out.

The therapeutic community as an environment for symbolization and as a treatment unit for the whole family poses a criticism toward the alienating power system. Describing the human problem as family and social crisis, working permanently with authority transference and shared responsibility, we seek to rescue the subject from slavery. And we paraphrase Spinoza, "One finds out he is a slave in the first place, then understands his slavery, and finds himself free in the end, once his needs are comprehended."

In short, our Community functions as a symbolization framework with a family strategy leading to decoding power relations inherent to human problems.

There is no way to describe in this presentation three other aspects supplementing those already stated:

- the Community as a labor community
- the Community as a play community
- preventive aspects of the Community

In the face of an impersonal world prone to anonymity, a world where affective shortcomings and narcissistic escape often generate margination, addiction and schizoid affective cutoff in the technological clockwork society, therapeutic communities will grow in number as they are a response to human needs.

NEWS FROM THE ASIAN PACIFIC REGION

Roy Johnston

President
Asian Pacific Federation of Therapeutic Communities

I bring you greetings from the Pan Pacific area, from our regional federation within WFTC--the Asian Pacific Federation of Therapeutic Communities. We extend to all of you, our sisters and brothers met here in San Francisco, and particularly to Alfonso Acampora and his team who have brought together this wonderful meeting, our best wishes for a successful and memorable World Conference the influences of which will chain out from this place to the extension, growth and strength of the TC movement right around the world.

As we extend to you these greetings, we ask you to focus on the region. As we do so we remind you than on the Pacific rim and up into Southeast Asia we have a zone of tremendous potential, of potential wealth, of great numbers in people, and of varying stages in development, both economically and politically.

Truly it has been said that our region is tomorrow's world, tomorrow's world center as the focus shifts from the old and the not so old to the new.

For this reason alone, the region is important. But from our own specific viewpoint, the very factors which make it the center of tomorrow are those which bring the plague of addiction to chemical substances.

And so we have within the region the Tragic Triangle. There is no way, except to those who are unprincipled, that it can be termed "golden." We have also the problems of the Peripatetic Pill, which somehow for the same "golden" reasons finds its way into the region from the tragic overruns of the pharmaceutical companies of Europe, American and Japan. And we have alcohol, long resident in the area, but brought new refinements by way of scotch, the juniper and the powerful pervading influences of the media.

Like elsewhere on this planet, we thus have within our region a population many of whom are potentiated to addictive substances, who have the ready wherewithal to meet that biochemical urge, and health and hospital systems not equipped in knowledge or training or even the will to understand the problem, let alone deal with it.

Thus it is significant and of interest to us all that many thousands of kilometers away from the formal and pioneering influences of men like Maxwell, Jones, Bridges, O'Brien and Deidrich, and with no knowledge of their profound influences in their own geographic areas, TCs were being established as an innovative response to a plague of addiction that was beyond both the capacity and the comprehension of the established health systems to cope with.

We have since in our region, thanks to the selfless international work, the many thousands of kilometers of numb-bum travel, of William O'Brien and lately Lars Bremberg, knitted into and gained much from the world-wide brotherhood and support of WFTC. And we are the better for that.

I am stressing these elements of origin in and from our region for we here, where establishment systems in many of our parts cannot so readily or easily be put in their proper perspective, have seen the need to remind ourselves constantly that the TC is an innovative response, that it stands taller and more effective away from systems which, seeing its success, have a yen to climb back onto its mode, and there are dangers in that.

To say we have special problems in our region is not to say we are alone in that. But we see the need for reminder of our innovative origin and what that meant at the time of innovation to be constantly before us.

Having with some delicacy and diplomacy traversed these important points, of which we shall say no more, what's going on in our region?

From Nepal across to Sri Lanka, through Thailand, Malaysia, Brunei, to Indonesia, the Philippines, Guam, Hong Kong, Japan, Australia, New Zealand and the South Pacific Islands of Fiji, Cook, Samoa--within this broad and populous region the TC movement is nurturing out well.

From within the Philippines with DARE, from within Malaysia with Pusat Pertolongan and the communities of Malaysia Cares, from within Thailand with Rebirth, from within SARDA in Hong Kong, from within New Zealand with Kahanui and Aspell and Johnston, has been the core of growth. In Nepal, in Sri Lanka, in Guam, in Australia, Indonesia are nurturings which will grow.

In this past year since our Rome Conference, the events which have been at the forefront have been the work of Pusat Pertolongan in Ipoh, Northern Malaysia, where the first Malaysian National Conference on Alcohol Problems was pioneered by Yakob Scholer.

Likewise in Selangor, Malaysia, we have established contact with the quite remarkable and purely innovative TC response Malaysia Cares with it Rumah Cahaya (for men) and Rumah Kepercayaan (for women) communities for those with drug problems. Pusat Care was established in January, 1980.

In Brunei we have opened up a continuing dialogue with the Director General of Health and Education on drug problems which are concerning that area and we have contact with colleagues there.

With United Nations and ILO representatives in the region we have established close working relationships which will enable the extension of the TC concept, particularly in areas where rigid authoritarian approaches have been dominant.

As we leave this Conference we go to Khatmandu in Nepal to an NGOs Conference where, thanks to Pio Abarro and the Colombo Plan, we will discuss TC extension.

But most important of all developments in the region, at this vital formative stage as we move forward, has been the great support and encouragement of the Council of Social Welfare of Thailand, which under royal patronage has helped provide a setting into which is being established a Pan Pacific Regional Training Institute for TC staff.

This project owes its present incipient existence to many elements of support: to the Swedish government, which is granting generous financial support; to WFTC through is International Development Committee, which provided the co-ordinating mechanism along with APTCs own channels; and lastly, but by no means least, to Lars Bremberg and his Swedish Valmotorp - Daytop TC systems which are providing the skills and the manpower for the establishment of the Institute which we would like to see called the Dag Hammersjold APTC Institute.

Lars Bremberg and his team are well suited to this challenging task. First, they have what we have seen from experience is essential: a long established TC system operating in their home country and a lack of colonialist tendencies for which there is no room in the region. They themselves have a highly developed and operational Training Institute. They are backed in their country by a government which has a genuine social concern for drug problems in the countries of our region.

Last, but by no means least, Bangkok, Thailand which ten years ago staged the international conference out of which WFTC was born, looks forward to the 11th World Conference at Bangkok in January, 1988.

Those, my friends, in brief, are the thought from and report on our Asian Pacific Federation, very much an integral part of our parent WFTC to which we say a warm public thank you, particularly to William O'Brien and Lars Bremberg.

THE FUTURE OF THE THERAPEUTIC COMMUNITY

Mitchell S. Rosenthal, M.D.

President
Phoenix House Foundation
New York

I am delighted for this opportunity to address the Ninth World Conference of Therapeutic Communities. And the issue I choose to raise today may be perceived quite differently by participants from the United States and those from other parts of the world. That issue is the simple matter of our survival, the future of the American TC, the role we are to play tomorrow in the treatment of substance abuse, if indeed there is a role for us in the constellation of treatment services now taking shape.

Because we have been, for so long, at the very center of drug abuse treatment in this country, it is not unreasonable for us to have assumed that we would remain there. But the 20 or more years during which we have been at the center of things does not give us squatter' rights. And a relatively low level of concern about our future is more an expression of our relative isolation within the world of social and health care service providers that it is a realistic reflection of confidence in our future.

There have been, to be sure, great changes in therapeutic communities since we first began working with drug abusers. But there have been even greater changes in the nature of drug abuse, in the perception of drug abuse and in the universe of drug dependent Americans who are and will become candidates for treatment.

As you know, the therapeutic community for drug abusers emerged during the 1960s as a self-help alternative to more conventional and less helpful means of treating drug dependency. It shared its name with those therapeutic communities that had been started more than a decade before in certain British psychiatric hospitals. But a name was just about all it shared with them. It had roots in far more ancient forms of communal healing, and its most immediate progenitor was Alcoholics Anonymous.

The point, of course, is that TCs evolved almost independently of the medical and mental health mainstreams, although not without the participation of a good many medical and mental health professionals. Nevertheless, we were outsiders. And that gave us the freedom to innovate, to experiment and to discover methods that worked. It allowed us to create communities that were truly "therapeutic"--caring communities that permitted long-term humanistic and psychodynamic involvement with clients, communities that provided a 24-hour-a-day context for learning and for change.

We were not given this opportunity because the medical and mental health establishments were convinced we could do a better job. We were given our chance because most doctors, psychiatrists, psychologists and social workers just didn't care. Some had been frustrated by their own attempts to deal with addiction while others were put off by both the nature of the patients and the nature of the problem. Drug addicts (in those days that meant heroin addicts and little else) were not patients many doctors cared to see. They were poor and generally disadvantaged. They had social, emotional and economic deficits. They were perceived as criminals, and many were indeed criminals. And they were considered incurable.

As for the problem of drug abuse, that was clearly becoming a crisis. But it was not a crisis most health care professionals recognized as medical. It was considered a social crisis, and what most troubled both the public and its political leaders was the spread of addict crime, not the spread of addiction.

Therapeutic communities were one of the ways in which certain communities responded to this crisis, a crisis many expected to be short-lived. It was felt that when the crisis passed, then TCs would dry up along with the public funding that supported them.

Only it didn't work out that way. The crisis persisted. Instead of blowing away, TCs proliferated. They grew in size, scope and sophistication. And the question today is, "Have they grown enough, matured enough, to survive a wholly different perception of drug abuse and the drug abuse crisis?"

We have had 20 years to show what we can do. And in that time, we have put together an astounding record of accomplishments:

- We have proven that drug abuse is curable.

- We have shown that "drug free" treatment is not only the most desirable model, but the most predictably effective as well.
- We have established the efficacy of the self-help dynamic and its vital significance to substance abuse treatment.
- We have demonstrated the important role that ex-abuser clinicians play in the treatment process.

Now this clearly should be enough to establish therapeutic communities as an essential component of whatever constellation of treatment services are developed in this country. But we cannot assume that it will be enough. Indeed, I suspect that it most likely will not be.

The reason lies in what else was happening during the 20 or more years during which the therapeutic communities were showing what they could do. Drug use grew from the relatively negligible levels of the early sixties to involve more than 50 million Americans by the end of the seventies. That is 50 million who have used drugs and more than 20 million who use them regularly. During this period, drugs spread across our country to communities of all sizes and all levels of society. Indeed, drugs are now more readily found in upper income homes than in lower income homes, and drug use is more prevalent in affluent suburbs than in the central city.

There has been, in recent years, great growth in what is misguidedly called "recreational" drug use and a shift from marijuana to more potent and dangerous drugs. More than 20 million Americans now have used cocaine. More than five million use it regularly. And an estimated five thousand new users try the drug each day.

Right now, we are seeing the greatest increases in drug use occurring within the workforce. The young men and women who were students when marijuana first moved into the schools and onto the campuses have come crowding into business and industry. They are our most "drug experienced" citizens -- the Americans most "at risk" of drug abuse because two out of three have already used drugs.

These young workers have been coming into the job market for more than a decade and a half. Researchers are now finding that one out of five male workers age 18 to 24 is a "problem" drug user whose productivity is 30 percent below par. Among working men 25 to 34, one in eight is a problem drug user. The work forces become increasingly vulnerable to drugs at its composition continues to change as more young "at risk" workers are hired and more older, low-risk workers retire.

The new "at risk" workers are the baby boomers, members of that oversized and much-named generation that was yesterday's "counterculture" and today's "yuppies." More significantly, they are today's parents as well. As this first drug-vulnerable generation ages, we can expect to see more adult drug abuse. At the same time, we can expect youthful abuse to persist and reach even higher levels as more children of drug-using parents reach adolescence.

Drug abuse is now a mainstream problem, and mainstream institutions are beginning to respond to it. It is no longer society's outcasts who are the victims, but society itself -- men and women with careers and homes, family physicians and health care insurance.

As more and more family physicians start looking for signs of drug abuse among their patients, more will find them. Even six years ago, in a University of California study, 150 consecutive general medical patients, making their visit to a practitioner, were screened for alcohol and drug abuse. The study found that more than 11 percent were using psychoactive drugs other than alcohol.

What will private practitioners do once they start automatically checking for indications of drug abuse? Where will they send their drug-abusing patients? This is today's doctor's dilemma. The reason, I suspect, that more physicians aren't on the lookout for drug abuse is that they aren't too sure what they should when they find it.

Industry, too, has a dilemma. A growing and already substantial portion of the workforce is composed of drug abusers. Much has been written of late about how industry is attempting to identify them. Urine testing has become a "hot" issue for the press, civil libertarians, and labor negotiations. But the most difficult question, that has yet to be satisfactorily addressed, is, "Where will industry send its drug-troubled workers for treatment?"

Ours is a supply and demand economy. A new (and new kind) of demand for drug abuse treatment is being answered by a rapidly-growing supply of treatment alternatives. Most of them are from the medical and mental health mainstream, many of them private, for-profit, high-cost and covered by health insurance.

What we are seeing in certain areas, most notably in that major city just down the coast from here, is drug abuse treatment as a growth industry. What should rightly concern us is how much of the treatment now becoming available is designed to respond to considerations other than patient need, to career demands and the prejudices of employers, to health care coverage and distinctions of class.

Now I am not for a second suggesting that there is anything inappropriate in this sudden diversion of the medical and mental health mainstream. Their new interest in drug abuse is a legitimate response to growing patient needs. We may, of course, find it ironic that drug abuse has finally achieved unchallenged recognition as a medical problem now that mainstream patients are its victims. We certainly should be quick to condemn those opportunistic practitioners who are now bringing what we know to be ineffective and inappropriate treatment into what has become, to some degree, a seller's market.

But our chief concern must be to determine what role therapeutic communities are to play in this new treatment environment. This is not necessarily an issue of concern to our European colleagues. Indeed, we may well look to some of them for guidance. For the most part, their TCs have tended to enjoy strong linkage to established medicine and mental health.

I believe that we in America have two choices. The first is to restrict ourselves to the treatment of our "traditional" clients. The trouble with this is that most of us have long since moved away from our initial client base to treat a variety of drug abusers. It is one of the ways in which therapeutic communities have matured -- demonstrating the capacity to adapt treatment methods to new client populations, dealing with adolescents, for example, and treating working men and women.

But are the changes we have made to accommodate a greater variety of clients sufficient to keep us near the center of the treatment scene? I am not convinced that they are. I do not believe that therapeutic communities can go it alone any longer. Had we not evolved independently of the medical and mental health mainstream, we probably could never have developed the treatment methods we did, methods which many in the mainstream are now eager to embrace. And we probably could not have demonstrated that drug abuse is curable. But, if we are not now prepared to work with more traditional medical and mental health professionals, then there is a good chance we will not survive the rationalization of drug abuse treatment services that is certain to follow the rapid expansion of the next few years.

How, then, do we prepare ourselves to work with and join the doctors and psychiatrists, psychologists and social workers whom many of us have considered hostile to therapeutic communities? We must recognize here how many professionals have long been involved in therapeutic community treatment and realize that these men and women became involved because they recognized what the TCs had to offer. More and more health and mental health care professionals are coming to realize that we may have something to teach them. But we will find too many unwilling to learn from us until we overcome some of the structural problems of our independent past.

I believe it is most important for TCs today to demystify TC treatment, to professionalize clinical practice and to start seeking more opportunities to collaborate with mainstream medical and mental health agencies. To demystify TC treatment we must recognize that what we have is a model and not a prescription. We are strong on description and weak on analysis. There is no broad conceptual framework that provides a basis for understanding the working of the therapeutic community. Indeed, there is no single, published codification of generally-accepted TC principles and practices. What does exist generally fails to reflect the more recent changes in TCs, the ways in which we are adapting to new client populations.

The lack of a solid conceptual basis for our work has meant almost total reliance on practical instruction for our clinicians and relatively little theoretical input in the training process. We have used what amounts to an apprentice system to train former clients to become skilled clinical workers.

Now, there are a great many virtues to the apprenticeship model. It is one that every profession initially employed. And it has worked amazingly well for TCs. It has made our former clients a source of strength and a means of renewal. But it has shortcomings, and these shortcomings become most evident when we attempt to modify our methods and adapt our programs. We simple ask too much of our ex-addict clinicians and give them too little. What is amazing to me is how rarely they disappoint us, how often they are able to struggle through to an intuitive understanding of questions they should be prepared to deal with conceptually.

We have made efforts to professionalize clinical practice. The credentialing program of our national TCA is a fine beginning. I am not arguing here for a more rigid kind of credentialism, the kind that would drive talented and dedicated clinicians from the field. I am asking that we broaden and deepen our approach to training, that we work together on ways of making true professionals, non-degreed professionals, of the men and women who are most responsible for our treatment successes.

I believe that we must undertake, over the next several years, the creation of new resources, including a body of material that will provide the solid conceptual language we need to describe ourselves, not only to our more traditional colleagues in medicine and mental health, but to ourselves as well and to our clinicians. We must start developing resources for training that will support the professionalization of clinical practice in the TC. I do not think we can accomplish any of this individually. I am convinced we must work together, pooling resources and sharing talents, to accomplish these tasks.

We have got to collaborate with each other to make it possible for us to collaborate with more doctors and psychiatrists, more psychologists and social workers. If we do not, if we are too proud to make the effort, if we are unwilling to share what we know with mainstream medicine and mental health, then it is entirely likely that they will attempt to use the methods we have developed without understanding them. They will attempt to use, as they already do, our TC-trained clinicians without understanding what they can contribute.

What will happen then to therapeutic communities? Well, my best guess is that we will become incidental to the main thrust of drug abuse treatment in this country and that patients will suffer as mainstream professionals struggle to learn for themselves what we have learned over the past twenty years. TCs would survive. But they would play a diminished role and contribute little to the further development of drug abuse treatment in America.

SUBSTANCE ABUSE AWARENESS IN CALIFORNIA

Chauncey Veatch III

Director
Department of Alcohol & Drug Abuse
State of California

I bring you greetings today from the governor of the state of California, George Deukmejian. He is unable to be here today and he regretted that because this community is very important to him. Very briefly, we have a proclamation from the Governor, and I'd like to wish you the very best as you take everything that you've learned at this conference back home as you prepare for next year's event in Sweden so that it can be as successful an event as the one here in San Francisco in the state of California in the United States.

From what I've been told, and listening to those of you who have been around, the Ninth World Conference is, perhaps, the most successful to date. We're very pleased about that. There are people from 21 countries here. There are over 500 participants. The conference started off on a positive note with a 10k Run for Recovery the very first day. And after I looked out and saw all of you here this morning, my eyes focused on the young people I see here in the very first row. When I see the young people that are here in San Francisco today, I think about how important they are for all of us because as we struggle on a daily basis to combat drug abuse, in many ways the young people represent a thread that cuts across the fabric of every society on this globe and one that we all feel so deeply about. I believe that we can make a difference today and in the days that follow so that the quality of life for our youth will be much greater than the quality of life that we have today.

There are many things that do come to my mind, but there's one thought that stands out above all others, and I'd like to share that and share the proclamation from George Deukmejian, the Governor of California. And that thought is about Robert Kennedy, who died in this state 8 years ago, who once said that too often we feel that there's nothing that one man or one woman can do against the array of the world's ills. But each time an individual stands up to fight injustice or poverty, you send out a ripple of hope, and those ripples cascade together forming a wave which overcomes the greatest walls of oppression.

Surely, all of us believe that the battle that we wage is as important as any battle in any society across this globe. I wish you continued success in your battle. Our thoughts and our prayers go with you as you leave this great city and go back to your homes. We hope that this has been a valuable conference for you. I'd like to thank Alfonso Acampora on behalf of the Governor and the people of the State of California.

I also see that the Monsignor is here, and I'm delighted to see him. I went to Notre Dame and our mascot is supposed to be the Fighting Irish. I always wondered why we had a redundant name for a mascot --- Fighting and Irish!

I'd like to present this proclamation firstly to Alfonso Acampora. I'd like to read the message from the Governor as I present this to you personally. The Text of Proclamation reads:

> "Whereas an estimated 1.5 million Californians are problem drinkers; and whereas as many as 90% of our youth have reportedly tried alcohol and 64% have reportedly experimented with illicit substances by their senior year of high school; whereas approximately 4,500 Californians died in 1984 as a result of alcohol and drug abuse; and whereas the cost to California for treatment, lost productivity, crime and property associated with alcohol and drug abuse is $17.7 million annually; and whereas the general public's awareness of the dangers of alcohol and drug abuse is necessary to combat this serious problem; whereas on September 1-6, 1985, San Francisco has the honor of hosting the Ninth World Conference of Therapeutic Communities which would explore better ways to educate and treat and maximize the elimination of the problems inherent in chemical dependency and alcohol abuse among our youth and adults; now I therefore, George Deukmejian, Governor of the State of California, do hereby proclaim September 1-6 as Substance Abuse Awareness Week in California and encourage all citizens to join in an effort to reduce substance abuse."

CHAPTER 3

TC RESEARCH: STATE OF THE ART

THERAPEUTIC COMMUNITY RESEARCH: OVERVIEW AND IMPLICATIONS

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Recent years have witnessed a burgeoning of research and evaluation in therapeutic communities. The emphasis of this work has been on treatment outcome, with fewer investigations of retention and treatment process. This paper provides an overview of the main findings and conclusions from this research. Implications for treatment, theory and further research are discussed, particularly with respect to the changing profile of substance abusers entering therapeutic communities.

The literature is not exhaustively surveyed, nor is it critically reviewed. Although attention was placed on recent research, the bibliography includes references that extend back to 1969. With few exceptions, the papers cited in the text are those reported after 1977. Much of the material in this review is drawn from De Leon (1984a).

Treatment Outcome

The effectiveness of therapeutic communities has been evaluated primarily through followup studies. Many of these have been executed by investigative teams engaged in large scale modality comparisons that include therapeutic communities. Others have been conducted on and by individual TCs. Most studies utilized self report which was considered reliable, although several contain corroborating çinformation from outside agencies.

Social Adjustment. All of the studies revealed that immediate and long term outcome status of the clients followed are significantly improved over pre-treatment status. Drug use and criminality declined while measures of prosocial behavior (employment and/or school involvement) increased (e.g., Barr and Antes, 1981; Brook and Whitehead, 1980; De Leon, 1984a, De Leon et. al., 1979; Holland, 1978; Pompi et al, 1979, Wilson and Mandelbrote, 1978, Simpson and Sells, 1982).

A few studies have utilized a composite index of successful out come, combining measures of criminal activity, drug use and employment. In these, maximally or moderately favorable outcome occurred in approximately half the clients followed (De Leon, 1984a, Simpson and Sells, 1982).

Psychological Adjustment. Although a primary goal of therapeutic communities is psychological adjustment, this domain appears in few outcome studies (e.g., Brook and Whitehead, 1980; De Leon, 1984a; De Leon and Jainchill, 1981; Kennard and Wilson, 1979). In these, psychological scores or profiles significantly improved at followup.

Phoenix House studies have also demonstrated a direct correlation between social adjustment (success rates) and psychological adjustment at two year followup (De Leon, 1984a; De Leon and Jainchill, 1981).

Time in Program. Studies which examined differences between clients who complete (graduates) and those who drop out of treatment indicated that the graduates were significantly better than dropouts on all measures of outcome. The investigations that analyzed time in çprogram (TIP) reported a positive relationship between favorable outcome and length of stay in treatment among dropouts (See Figure 1) (e.g., Barr and Antes, 1981; Coombs, 1981; De Leon, 1984a; Holland, 1983; Simpson and Sells, 1982; Wilson and Mandelbrote, 1978).

Who Are the Successes?. Research has yet to delineate a client profile that predicts successful outcome. Age, race and other demographic factors do not relate to outcome in TCs. In Phoenix House research, females do yield significantly better psychological adjustment than males at followup (De Leon and Jainchill, 1981). However, this difference in psychological outcome by sex remains to be replicated in other programs.

Figure 1

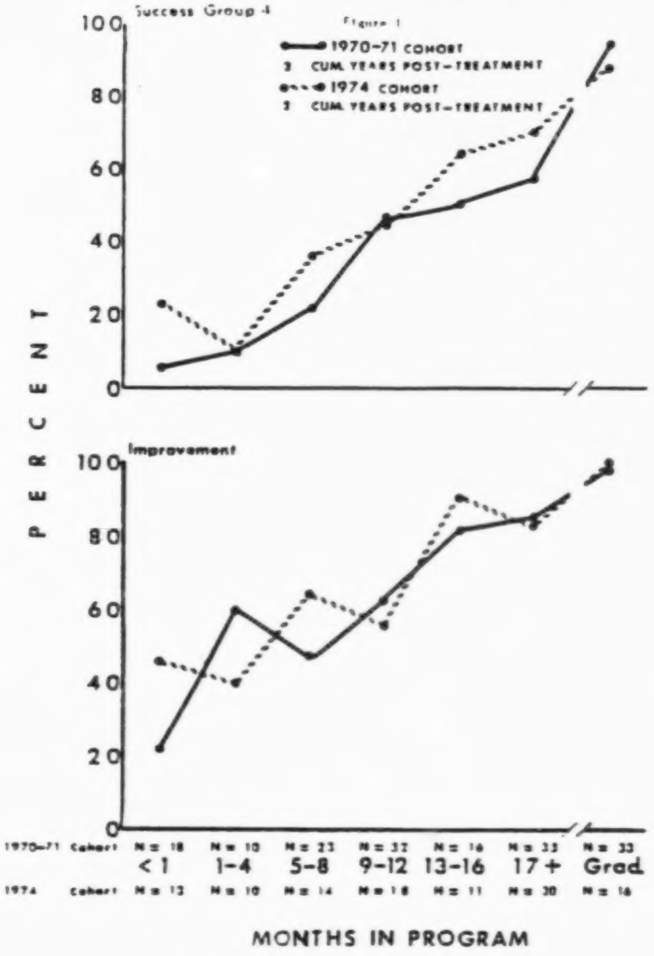
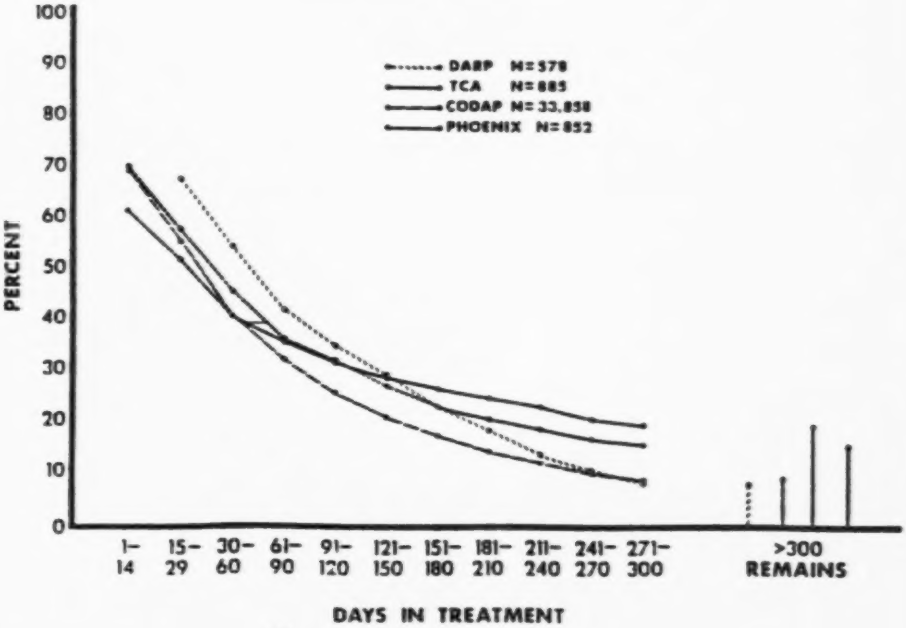


Figure 2

RETENTION CURVES FOR DRUG-FREE RESIDENTIAL PROGRAMS



Several background correlates of positive outcomes on drug use, criminality or employment have been identified, e.g., lower lifetime criminality, higher pre-treatment educational level, opioid as a primary drug (e.g., De Leon, 1983; Simpson and Sells, 1982). Though significant, these associations were small when compared with the effects of time in program; nor are they strong predictors of successful status measured with a composite index.

Retention

Time in program is the most consistent predictor of successful outcome. This finding stresses the importance of understanding retention as a phenomenon in its own right. Thus far, however, research has not yielded clear answers to three main retention questions: What are the retention rates? Who are the dropouts? And, why do clients leave or remain in treatment?

No client profile has emerged which predicts length of stay in treatment. Research reveals only sporadic and weak correlates of dropout involving demographic, primary drug, background characteristics, pre-treatment status and psychological adjustment. Generally, however, social background (lifetime) characteristics have not predicted long term retention, with the exception of less severe criminality.

Client status in the months prior to treatment is more closely related to retention. For example, those under legal pressure or whose health or lifestyle appears to have worsened, reveal somewhat longer durations of stay in TCs (Condelli, 1983; De Leon, 1983,; Holland, 1982).

Similarly, psychological profiles on entry into treatment fail to predict overall retention in treatment, although psychological factors still appear to be important. For example, several investigations indicate that early dropouts reveal higher levels of psychological dysfunction measured with standard paper and pencil instruments (De Leon et al., 1973; Sacks and Levy, 1979; Wexler and De Leon, 1977; Zuckerman et a., 1975). Some studies suggest that clients who showed less defensiveness and less denial of problems remain longer in treatment (De Leon, 1983).

One impressive finding obtained in a recent investigation involving a consortium of therapeutic communities revealed a striking relationship between psychological change during treatment and overall retention. Individuals who psychologically improved within the first several months after admission showed a significantly greater likelihood of continuing their stay in treatment (De Leon, 1980a). This finding has obvious implications for clarifying the relationship between client progress and retention.

Retention rates in therapeutic communities have received some attention in the literature (e.g., Brook and Whitehead, 1980; De Leon and Schwartz, 1984; Glaser, 1974; Sansone, 1980). The pattern of retention in long term therapeutic communities is orderly and predictable. Dropout is highest within the first 15 days of admission and declines sharply thereafter such that the likelihood of dropout decreases with length of stay itself (Figure 2).

Why clients drop out of treatment is a question that has not been adequately investigated, although hypotheses concerning dropout have been offered mainly from clinical impressions (e.g., Baekland and Lundwall, 1975; De Leon, 1984b; De Leon and Rosenthal, 1979; Heit and Pompi, 1977; Sansone, 1980). In Phoenix House followup studies, analyses of clients' retrospective reasons for dropout distributed equally between those relating to program problems (e.g., conflict with staff, views of treatment) and those that were more personal (e.g., wanted to continue using drugs, wanted to work). Program versus personal reasons differed by length of stay, with significantly fewer personal reasons associated with retention over 12 months in treatment (De Leon, 1984c).

Studies involving other therapeutic communities highlight the importance of the client's perception of self, the environment and circumstance in relation to dropout. For example, clients who enter treatment under legal or family pressure remained longer only if they perceive those pressures as negative (Condelli, 1983).

Treatment Process

Treatment process has been the least investigated problem in drug abuse treatment research. Ironically, the first process studies in TCs appeared more than a decade ago but their importance receded in favor of the need to establish firm information concerning treatment effectiveness. The relatively few process studies in the literature may be classified into 3 categories, studies of treatment change, direct investigations of treatment elements and client attribution of treatment influences.

Psychological change . Studies have examined clients' psychological change during their stay in programs without assessment of treatment components. They are reviewed as process studies since many of the psychological scores measuring change reflected program goals, e.g., attitudes, ego strength, emotional control, responsibility, self esteem, etc. Together with behavioral changes in drug use and anti-social behavior, these psychological changes during residency have strengthened inferences concerning the specific influences of treatment elements.

The studies employed standardized psychological instruments but vary with respect to design, number of variables measured and the number of observations during treatment (e.g., Biase, 1981; Brook and Whitehead, 1980; De Leon, 1974, 1976, 1980a; De Leon, et al., 1971, 1973; Kennard and Wilson, 1979; Sacks and Levy, 1979; Zuckerman et al., 1975). However, results are quite uniform in showing: a) the profiles or pattern of psychological scores is similar across programs and even cultures. For example, prominent are The signs of character disorder, personality inadequacy, mood disorder, poor self esteem and dull-normal intellectual level; b) overall psychological status improves significantly during treatment across most measures but generally does not attain normative or healthy levels. Larger improvements occur in self esteem, ego strength, socialization and depression. Relatively smaller changes occur in the more enduring personality features, e.g., the character disorder elements. Thus, drug abusers in the TC are psychologically similar and show significant improvement in most psychological domains, although long standing character traits are more resistant to change; c) psychological improvement post treatment generally exceed the gains made during treatment.

Studies completed at Phoenix House specifically correlated behavioral indices of drug use and crime (success status) with psychological improvement during treatment and at followup. Clients with an unfavorable success index at followup showed little psychological change during treatment or at followup. In contrast, clients who obtained a favorable success index had revealed significant psychological improvement during treatment and cont inued psychological gains at followup. This important finding offers indirect but positive evidence for the influence of treatment factors in the change process.

Treatment Elements . Some studies have addressed the relationship between specific treatment elements and client change during residential treatment. For example, results show significant reductions in self rated emotionality (depression, hostility, anxiety) and in physiological "upset" (systolic blood pressure) immediately following participation in encounter therapy sessions when compared with baseline measures (Biase and De Leon, 1969, De Leon and Biase, 1975).

Research at Daytop Village therapeutic community has çexperimentally evaluated the effects of a specific educational intervention (college credit courses) upon clients in a therapeutic community. Findings support TC assumptions concerning treatment process and role changes. The students revealed significantly enhanced self esteem over that expected from treatment effects alone in the TC (Biase, 1981).

Treatment process has been indirectly examined in studies of client perception of the therapeutic community environment (e.g., Bell, 1983; De Leon et al., 1980). Although preliminary, the results obtained across several programs are stable and orderly. All TC programs revealed a characteristic environmental profile that differed from hospitals and jails; and client perceptions of the environment were consistent with expectation concerning treatment change and length of stay. These findings support assumptions that traditional TCs are similar in philosophy, structure and practices.

Attribution. These studies have investigated client perceptions of their experiences in TCs. Generally, on measures of satisfaction, clients report a favorable experience in the therapeutic community and would recommend their particular residential program to others (e.g., De Leon, 1984c; Simpson and Lloyd, 1979; Winick, 1980). For example, successful followup status and length of stay in treatment significantly relate to satisfaction with treatment, the relevance of specific program components to followup status and client weighting of the relative importance of treatment and non-treatment influences upon their lifestyles since leaving treatment (De Leon, 1984c). Although clear, these findings must be cautiously interpreted, given their retrospective nature. Possible halo effects or dissonance factors might have influenced client perception of treatment experience and their own followup status. Nevertheless, the results firmly support hypotheses concerning the relationships between treatment experience, treatment elements and outcome status.

Summary

There are several conclusions from the review of the literature. First, a substantial number of admissions to TCs reveal favorable or improved behavioral and psychological status at followup. Notably, the percentage of positive outcomes increases directly with time spent in treatment. Research has yet to describe a client profile that predicts successful outcome, and only a few variables are consistent predictors of outcome other than length of stay. Second, dropout is the rule across TCs (and other drug treatment modalities) and the temporal pattern of dropout is predictable; most admissions leave treatment before maximally beneficial effects are rendered. However, relatively little is known about who drops out or remains in TCs. Typical client profiles in relation to retention have not been delineated, and there are no variable that are consistent or large predictors of dropout. Research has not clarified the reasons for dropout, although studies point to the importance of the client's perception of the treatment environment and of their problems in influencing retention. Third, there is relatively little research on treatment process in TCs. The findings obtained support inferences concerning the process of change but the process itself remains to be investigated.

Some Implications for Research and Treatment

Perspective on Treatment Effectiveness. TCs are effective when evaluated in terms of their principle aim of modifying both social and psychological adjustment. However, this conclusion remains tentative in light of familiar methodological considerations, the most serious of which is the lack of control groups. The followup samples studied may be self selected to seek, remain in and benefit from the TC; or, perhaps to improve without any treatment. Thus far, however, solutions to these selection problems have eluded research strategies. There are ethical problems in withholding treatment; and assembling matched controls or comparative treatment groups through random assignment has not been feasible.

The methodological difficulties stress the need for a revised perspective on the interpretation of treatment outcome research which would reflect the multivariate complexity of individual change. One such perspective has been outlined for therapeutic communities in other writings (De Leon, 1980b, 1984a; De Leon et al., 1982). Briefly, successful outcome emerges from an interaction of client, treatment and non-treatment influence. The specific impact of the treatment experience is most apparent during and immediately following residency; thereafter, though less recognizable, treatment effects may integrate with (or perhaps alter) the contribution of later experiences in maintaining successful status.

This perspective emphasizes several assumptions that are also relevant for the design and interpretation of outcome studies. First, the drug abusers can be classified according to differences actually observed in relation to their treatment involvement. This suggests that the universe of drug abusers can be quadrasected, by definition; those who come to treatment and those who do not, and within each, çthose who make positive changes and those who do not. The natural history or treatment outcomes for these groups reflects their unique composition. For example, those untreated drug abusers who mature out of their addiction life-style are simple different people from those who enter treatment and change. This assumption then, avoids the dead end criticism of the no-treatment control since the four groups do not serve as controls for each other.

Treatment effectiveness should be assessed for those clients who seek or perhaps remain in treatment settings. Comparisons involving the clients in the three other groups, however, could reveal much about individual differences and the many influences that contribute to the change process.

Second, client change reflects an interaction between the individual and treatment. This implies mutual, bi-directional influences between the person and the treatment environment. Thus, treatment influences as unique measurable events are not readily extractable. Furthermore, the global treatment experience itself is an episode, one of many experiences in the individual's continually changing status. Thus, "proving" a treatment influence is less relevant than identifying its particular contribution to a continuing process of individual change.

Third, the primary source of information about this process is the client's own view of the relevant influences. External corroboration of client change through records or other testimony validates the fact of change, but does not reveal the reason for change. In the last analysis, it is the client who weights the relevant influences in his or her life.

A perspective on Retention. Dropout is a persistent but perhaps ç the least understood problem in substance abuse treatment. For therapeutic communities in particular, the importance of retention is illustrated in the fact that research has established a firm relationship between retention and outcome. However, most admissions to therapeutic community programs leave residency, many before treatment influences are presumed to be effectively rendered.

Within the context of the research reviewed, a perspective on retention can be drawn which guides the interpretations of dropout and hypotheses for further research. The drug users who seek treatment, particularly to one modality, are more similar than different. Thus, it is not surprising that research on their social and psychological characteristics reveals relatively low variability, and hence, little power to predict success or retention.

Nevertheless, those who seek treatment could be diverse in ways that have not yet been fully explored. These presumed differences reflect not who clients are, in terms of fixed background characteristics, but how they perceive themselves, their circumstances and their life options at the time of treatment contact. Assessment of these differences would focus upon at least four domains of client variables which alone or in combination affect dropout:

1) Circumstances (extrinsic pressures): These refer to external influences to seek and remain in treatment exerted by family, personal relationships, health and legal conditions, employment, educational and fiscal matters;

2) Motivation (intrinsic pressures): This refers to the severity of the problem (felt dissatisfaction, fear, pain) and the expressed need for personal change;

3) Readiness: This refers to the perceived need among motivated individuals to elect treatment to assist in personal change compared with non-treatment options, e.g., self-change or religious offerings;

4) Suitability: This refers to the client's appropriateness for, understanding and acceptance of a particular treatment approach.

Treatment Process . The TC cannot improve what it does without clarification of its process. Studies must render explicit the correlation between actual events in treatment and change in client status. It is this interplay between treatment elements and client change which defines process.

The first step in illuminating treatment process is a codification of the TC's perspective, basic elements, assumptions and practices. Several workers have undertaken efforts in this area (e.g., De Leon, G., 1981; Sugarman, B. 1981).

A next step involves development of program based research capability. Since treatment process research imposes heavy strains on program activities, it is understandably resisted by staff and administration. Thus, acceptance of process studies is facilitated by research teams who know the TC, can integrate with its staff, and can serve in educative roles (De Leon, 1979).

Alternatives to Long Term Treatment. Traditional TCs are highly effective for a certain segments of the drug abuse population. However, those who seek assistance in TC settings represent a broad spectrum of clients, most of whom may not be suitable for long term residential stay, as is evident in the high early dropout rates.

The issue of client diversity underscore the necessity for TCs to develop alternatives to long term residence and skilled diagnostic assessment capability. These, however, appear to counter the traditional TCs open door policy for admissions. Nevertheless, wise assessment of individual differences can only enhance the therapeutic community's capability for retaining those suitable for residential treatment and for offering appropriate options to others who do not enter or stay in long term treatment. Some TCs have acquired a diagnostic capability, although explicit clinical criteria and appropriate instruments for assessment of client differences remain to be developed.

TCs can offer service alternatives other than long term residence or referral to other modalities. For example, its method can be modified for both outpatient and short term residential models. There is an underlying concern that modification could dilute the unique strength of the TC approach itself. Can the traditional TC engineer its social and psychological effects without the 24-hour influence of the residential setting; or can it maintain the integrity of its community dynamic under a short term residential regime? These questions remain to be empirically answered. However, the issue of individual differences for the TC need not be one of changing itself, but adapting what it knows and does for the changing client. It is not whether long term residential treatment is appropriate for all clients; it is clearly not. The task, then, is to develop new ways of delivering the basic TC message and new tactics to produce its unique therapeutic impact.

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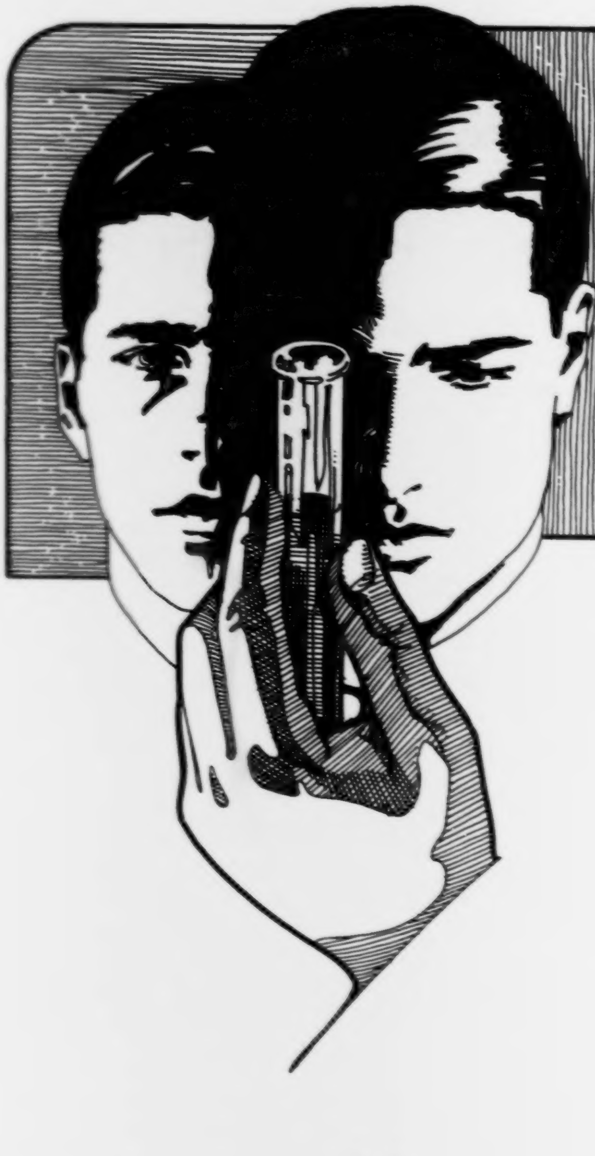

EMERGING CROSS-CULTURAL TC RESEARCH

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The authors wish to acknowledge the participation of the Daytop and Ce.I.S.T.C. residents and the collaboration of Letizia Pappalardo and Anna Maria Bianchi.

The last decade has seen a strong and consistent growing interest in the Therapeutic Community (TC) movement. This interest has been most prominent in the international community. Nations outside of the United States have recognized that the TC offers an effective drug free response to the treatment and rehabilitative needs of addicts and substance abusers. It offers an approach that is committed to responding to the psycho-social complexities of drug addiction and abuse.

The rapid growth in membership of the World Federation of Therapeutic Communities (WFTC) is just one reflection of this interest. Another aspect is the increasing involvement which Daytop Village has had in providing TC technical assistance to programs in foriegn countries. Daytop has developed the capability to strategically assist new TC programs in a number of countries including Italy, Sweden, Ireland, Canada, Norway, Brazil and the Phillipines. While TC programs in each of these nations are independent, Daytop, when requested, has dispatched staff to initiate new programs; provide for administrative development and support and assist in introducing the TC concept to foreign policy makers to help foster program understanding and acceptance. Each of these programs has progressed within its own cultural context and each has adapted and modified the TC philosophy. These modifications have shown us that the TC philosophy can generate effective treatment variants when adapted by creative TC colleagues while maintaining program integrity. It is this successful establishment of international TC programs that has fostered an increased interest in the area of research.

My comments today are intended to share with you information about the first TC cross-cultural research study which we've initiated between Daytop Village (New York, U.S.) and Ce.I.S. (Rome, Italy). The research emerges from an atmosphere which is committed to the development of the TC across international borders. Such a project could only have been undertaken where receptive, supportive and qualified collaboration existed. While teaching and training staff from Ce.I.S. in 1984, I was gratified by the degree of interest and enthusiasm shown toward the TC research program conducted at Daytop. It was soon apparent that these findings, which developed over the last six years in the Daytop Miniversity Project, had conceptual and clinical value to the Ce.I.S. staff. The scope of these findings provide the basis for this cross-cultural research project.

In the broadest sense, the research explores the psychological and self concept development which is part of successful TC treatment for addiction. We expect that the research findings will help to

- empirically define and describe international TC programs and residents;
- assess the different forms of TC treatment i.e. ambulatory, residential, short and long term;
- enhance TC programming by developing common methods of measurement;
- empirically support the development of TC treatment internationally.

To accomplish this TC cross-cultural research the following conditions existed between the Daytop and Ce.I.S. programs:

Concept Equivalence - A mutual agreement and consensus about the area of study; self concept and psychological development of residents. The equivalence was enhanced by on-site training and staff development.

Program Goals. The treatment approach of both programs, Daytop and Ce.I.S., are comparable and adhere to a TC drug free philosophy.

Behavior Goals. Both TC programs are based on a process of socialization, behavior change and personality development.

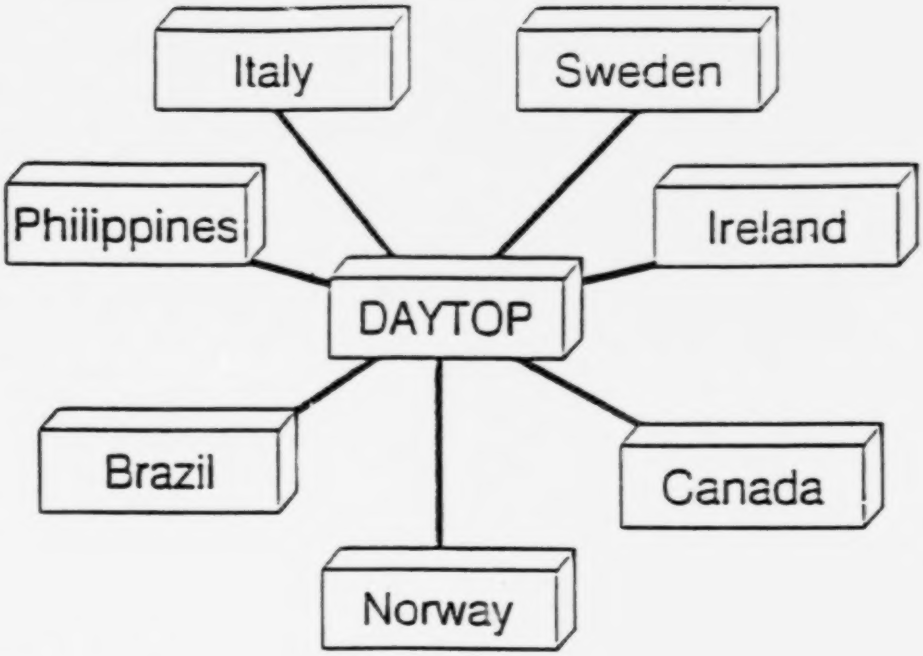

Exhibit 1

T.C. Cross-Cultural Comparability

• Concept Equivalence	(Self Concept)
• Program Goals	(Drug Free)
• Behavior Goals	(Socialization/Personal. Dev.)
• Treatment Approaches	(Encounter; Peer Self-Help) (Heirarchy; Re-Entry)
• Resident Profile	(Age, Sex, Drug Abuse)
• Linguistic Equivalence	(Accurate Translation of Self Concept Scales)

Exhibit 2

Treatment Approaches. Both programs rely on the encounter, peer self-help, a hierarchical social TC structure and a defined re-entry process.

Resident Profile. Both programs have comparable resident populations with regard to age, gender, marital status, drug abuse histories and type of anti-social behavior.

Linguistic Equivalence. A cross-cultural study requires that the testing instrument be translated accurately. The instrument was refined after two separate translations and a pilot test period. Translations involved a collaborative effort with individuals who were bilingual and worked within the TC setting.

After having insured that the above conditions were met, the first phase of the research work was successfully deployed. Data collection focused on three treatment environments of the Ce.I.S. This included the entry (Accoglienza) group - they had completed an average of 3 months in ambulatory treatment; the long term re-entry group - they had completed an average of 18 months of residential TC treatment; and the short-term residential group - they had completed an average of 6 months of residential TC treatment. I will briefly report some of the initial Ce.I.S. findings for the Entry and Long Term Re-Entry group. Analysis are being currently conducted, but as a result of the initial outcomes a model for cross-cultural TC research is developing successfully. Such a model will benefit international TC research, program evaluation and development. I wish to emphasize that we have found self concept and psychological assessment measurement to be adaptable in the Ce.I.S. treatment settings. Future reports will emphasize their use in international corss-program comparisons.

Presently we note that in this phase of the Ce.I.S. study the Entry and Re-Entry groups included 30 residents in each, with an average age of 23 years and 24 years respectively. The gender distribution was 80% male and 20% female in both groups. The primary drug for both groups was heroin with a low incicdence of poly drug abuse.

Profile and statistical analyses demonstrated patterns found in previous Daytop self concept TC research. The scores of the Entry group reflect a characteristically disturbed level profile and poor self concept scores, particularly in the areas of moral-ethical self and family self. These scores are accompanied by deviant self assessment scores in the areas of general maladjustment and personality disorder. The pattern as reflected in a composite score is similar to that classified as a personality disorder or emotionally unstable personality.

These Entry group residents responded to a daily regime of TC based ambulatory care combined with a program of family education and therapy. Despite their self concept patterns and addiction histories, more than 85% remained with the program, were drug free and progressed from ambulatory to residential TC when followed up one year later. This ambulatory Entry (Accoglienza) program is one unique example of the successful adaptation of the TC concept which was designed effectively for the Italian cultural and social setting.

When we analyzed the results of the scores of the Re-Entry group, we found evidence to support gains made within U.S. residential TC treatment. The Re-Entry group had participated an average of 18 months in residential TC treatment and an additional prior 6 months in the ambulatory TC program. Because the Entry and Re-Entry groups shared equivalent characteristics, we conducted a comparative analysis. Results showed significantly higher positive scores in all areas of self concept and improved psychological status scores.

There were also significant reductions in the general maladjustment and personality disorder scores. We are in the process of following up both groups for a second assessment in order to study their within treatment and post TC treatment status. Initial comparisons with Daytop U.S. data suggest directions for further exploration. The data indicate that the Italian Ce.I.S. residents report less deviant levels of self criticism and less psychological defensiveness at both the early and latter stages of treatment. This is corroborated by observations of staff and of the clinical interventions and strategies used. Also, despite presumed stereotypes of increased Italian family involvement, we have found an equivalent level of positive development of the family self by both Daytop and Italian residents who participate in long term TC treatment.

These early outcomes offer strong encouragement for future collaboration and build from the TC research base which has been developing over the last two decades. Research of this type will offer a basis for increased understanding of the process of successful TC treatment in different countries and cultures. It will provide empirically based information which W.F.T.C. members can share with helath workers and policy makers in their own nations, pointing to the effectivenss of TC treatment in the face of a worldwide increase in drug addiction and substance abuse.

Last year at the W.F.T.C. conference in Rome, we first introduced the concept of this Project. We look forward to our meeting next year in Eskilstuna to report on how these research activities are progressing with growth of the international TC movement.

	Daytop	Ce.I.S.
Age	26 yrs. (17-43)	24Yrs. (17-29)
Gender	75%m 25%f	75%m 25%f
Race/Ethnicity	Mixed	Same
Primary Drug	Heroin 59%/Polydrug	Heroin 100%
Time in Program	3/18 mos.	3/24 mos.

Exhibit 3

Features

- Successful Cross-Cultural Self Concept Research
- Comparable Treatment Program and Residents
- Empirical Support of Int'l. T.C. Treatment
- Unique Cultural Differences
- Design for Future Int'l. T.C. Clinical Research

7

Exhibit 4

FOLLOW-UP OF FORMER RESIDENTS OF THE EMILIEHOEVE, A TC FOR DRUG ADDICTS

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INTRODUCTION

A question that most visitors of the Emiliehoeve, the first T.C. for addicts founded in the Netherlands, asked is: What is the effect of this intensive treatment program? It was also the question I had a few years after I founded, in 1972, this Community in a deserted old farm on the premises of a psychiatric hospital in the Hague.

A follow-up research project was developed at the Department of Preventive and Social Psychiatry of the Erasmus University in Rotterdam where I, at that time, was and still am teaching medical students.

Before I shall present some of the preliminary results, I shall give some information on the development of the Emiliehoeve program and some background information of the residents treated.

The Emiliehoeve program was started as an alternative for existing treatment programs in the early 70's because they were not successful in stopping the addiction of their clients.

Drug addiction was a new phenomenon in Holland and the treatment consisted in those days of outpatient treatment at the clinics for alcohol, where the drug addicts were also referred, and admissions in psychiatric hospitals. In the outpatient clinics Methadone treatment was introduced in 1969. In fact, I was one of the first doctors in Holland prescribing it to opiate addicts. It took me two years to find out when I finally decided to apply urine tests, that all of my clients were either continuing to use their opiates or taking other drugs or pills.

In the psychiatric hospital where I worked, I discovered that the addicts did not change their behavior; they only learned to combine their drug abuse, that they continued after admission, even in closed wards, with the use of tranquilizers they had obtained from fellow patients.

A show performed in a theater in the Hague by re-entry residents of Daytop Village in New York on the history of a resident that came to this T.C. program made me aware of the existence of a different approach. This was the first occasion that I saw recovered addicts.

With a group of professionals, a psychologist, social workers, an artist, and myself, a psychiatrist, we started a T.C. with little or no experience in the treatment of addicts and none with TCs.

The residents were regarded as sufficiently grown-up to be involved and trusted to make decisions in a one man-one vote way.

There was no clear structure in the program, little or no limits were set to the residents behavior and the therapy groups, run along psycho-analytic lines, focused on the past rather than on the here and now. Although no methadone was given, tranquilizers and sleeping pills were administered during the first few weeks of admission.

The program during those first months can be characterized as extremely chaotic, the most negative students served as role models and the residents did not change addictive behavior.

After the therapeutic staff had attended a marathon encounter group run by a former director of a Phoenix House in New York, and later the first director of Phoenix House, in London, the program underwent drastic changes. It became clearly drug-free from the day of admission, and, most important, encounter groups were started in which behavior was confronted and the residents learned to express their emotions in a direct way.

This was five months after the start of the program and the program went into its second phase. The population grew in the course of the following years form the original ten residents to forty.

Step by step, further elements in the program: a hierarchical resident structure, verbal reprimands called "hair-cuts", learning experiences and different levels in the treatment program (introduction, new residents, middle group, older residents, re-entry from a separate house in the city) were introduced following the model and concept of the TCs in America. the staff was supported in this by visiting ex-addicts who had been staff in America and British TCs who were employed as consultants. After the radical change the results obviously improved. Ex-addicts who had graduated the program could be included in the staff. Whether the other added elements also increased the positive outcome had to be found out through follow-up results of the research that was started in 1974.

RESEARCH BACKGROUND

The first 240 residents were admitted during a five year program after its foundation in 1972. Readmissions within one-half year after departure were regarded as being the same admissions. Readmissions after having been out of the program for more than one-half year are excluded in this report.

Of the readmissions in 1972 through 1974, 71 percent of the residents had no other than primary education. During the following years the education level went up. (Only primary education levels in 1984 was 34 percent.) During the course of the years, fewer residents came from lower social class background (estimated) from 37 percent in 1972-74 to only 9 percent in 1983.

The mean age of 20.6 in 1972-74 raised to 21.1 in 1976 and 24.4 in 1983.

There had been no change in referrals from courts (9-10 percent); 53 percent of all residents had been in prison before admission.

Over the years the male-female ratio has been 7:3. During the years 1972-76 there were no residents from minority groups. In 1982 there were 17 percent minorities, mostly from Surinam.

The abuse of different drugs was in 1972-74 an average total of 2.87; in 1976: 3.77. In 1983 it was 3.97. Over the years there has been a considerable change in the drug use patterns apart from the trend to use more different drugs.

In 1972 the drugs of preference were amphetamines, while in 1983 they were clearly replaced by opiates as the most popular drugs. From 1976 methadone became more easily available. In the same period the duration of the addiction before admission increased from 3 to 7 years.

THE FOLLOW-UP RESEARCH

The first 240 residents were seen in a face to face interview usually at the place were they were living by students who worked yearly during five months in the project as part of their study; each year different students, two to five in number. To get acquainted with the program they lived for two weeks in the Emiliehoeve T.C. before they started to visit ex-residents. A group of 60 residents of a T.C. in Rotterdam, Essenlaan, admitted in a period when this community had a similar concept and structure as the Emiliehoeve, was visited as well.

Also, a group of 60 people was interviewed that visited the induction center, was accepted but dropped out before admission. All ex-residents were visited at least half a year after they had left the program. They were reinterviewed a maximum of three times in a maximum period of five years, unless they had clearly relapsed in their addictive behavior.

Although many successful ex-residents were followed-up in one or more further interviews it was decided to choose a two year period after discharge to consider outcome results.

The main reason was that 80 percent of the first 240 residents of the Emiliehoeve program had been interviewed after they had stayed at least two years out of the program, while the percentage seen three or more years after discharge was considerably less.

Another reason is that research so far showed that almost all relapses already occurred within one year after clients had left a program and that more factors unrelated to the treatment in the T.C. were affecting the outcome results when more time had elapsed after they left.

The program was divided into subsequent phases. The first one has been described above as the loosely structured program before confrontation of the current behavior had began in encounter groups. During the following phases other elements apart from the encounter groups, the setting of clear limits, and the drug-free philosophy were added.

The results were allocated to the phase during which they were admitted. Those admitted during the last four months of a phase were excluded when the phases were compared as they may have stayed for a considerable time in treatment during a following phase.

As the goal of the program was complete abstinence from hard drugs, absence of any addictive behavior, criminal acts and serious psychiatric disturbances rather rigid criteria for success were chosen:

Ex-residents should have during the first two years after the program: no use of any hard drugs at any time, no use of cannabis, tranquilizers or sleeping pills for more than two consecutive days. (No regular or daily use in an addicted way.) No arrests, no admission to psychiatric hospital and, no treatment for addiction.

As a period of less than two weeks spent in the program was considered insufficient to expect any change, those clients (30 out of 240) were excluded and will be considered as a separate group. Follow-up results of this group and the intake-only group (clients that dropped out before admission) as well as of the Essenlaan T.C. will be reported of later.

Of the 240 residents, 141 follow-up evaluations could be used. Out of a total of 240 admissions, there were 5 records incomplete at admission, 36 spent less than 14 days in the program, 9 had to be excluded as the main reason for admission had been psychiatric disorder rather than addiction, and 49 could not be traced or refused the follow-up interview. This left 141 subjects in the follow-up study.

Results of residents allocated to different phases in the program were compared. Also outcome was compared with time spent in the program. Followup results of a cohort of residents present on one day were compared.

RESULTS

The success percentages following the abovementioned criteria of two years "clean" after discharge (residents staying in the program less than 14 days were excluded) are:

	N=48	N=37	N=56	N=141
Time in program	14 days - 4 months	4 months - 1 year	more than 1 year	Total
2 years clean	21%	16%	59%	35%

Of the total of 141, 33 percent of the males were successes and 39 percent of the females. However, among residents staying more than one year there was no sex difference. The difference appeared to be related to the finding of more early drop-outs among males.

There is a significant difference in success between the groups up to one year combined (19 percent success) and the group who stayed in treatment for more than one year (59 percent). There is no significant difference between the groups that stayed less than a year.

There was no significant difference between residents leaving before graduation who stayed longer than one year in program and residents who graduated.

There was no significant difference in outcome results using the sharp criteria between the residents of the different phases in the development of the treatment program apart from phases one, where none of the residents became successes.

There was also a clear difference in the percentage of early drop-outs, residents staying less than 14 days, between the first (33%) and the latter phases (14%).

For the total this percentage was 15 percent (36 of the 240 residents).

Of all 240 residents 28 percent stayed longer than one year in the program.

Of those residents who stayed at least two weeks 34 percent stayed longer than one year (36% when residents of phase one are excluded).

Compared with the findings of De Leon (1984), from seven TCs combined, we see the following:

	De Leon	Emiliehoeve
2 weeks	70%	85%
4 months	32%	48%
10 months	15%	32%

To conclude I shall briefly mention the following finding to be published elsewhere. Twenty-three residents staying in the community on one randomly chosen day were compared on the following results. Twelve had graduated from the program, eleven had dropped out before graduation, eleven of the twelve graduates were successes on the above described sharp criteria and only one of the eleven dropouts. Of the total population 50 percent were successes when seen at follow-up interviews at least one year after they had left the program.

DISCUSSION AND CONCLUSION

Follow-up research is not only difficult to carry out, it is also difficult to interpret. When we use the here described sharp success criteria it must be understood that the residents not falling in this group are not all total failures. Many of them had only a short relapse and are doing now quite well. Some only used once and decided that it was not what they had expected. Some work as respected staff members in the treatment programs.

There are other methodological problems to be faced. If all residents in a study are included also residents that stayed only for a day, you are not measuring the intended treatment. If you only consider graduates you look only at a small group of the total of clients admitted (for Emiliehoeve - 22 percent).

There was no difference in outcome found between the phases, except between phase one and the others. This is in line with findings of the DARP follow-up study.

More refined research is needed to arrive to definitive conclusions whether quality of the program is a factor in determining success.

Success improved considerably, however, as residents stayed in the program longer than one year.

It is clear that a drug-free philosophy, encounter groups, and clear limit setting to destructive behavior were important to reach any good results in the Emiliehoeve program.

In further analysis only the residents admitted after phase one are analyzed in the follow-up to be compared with the pre-treatment situation recorded in the admission forms and with the results of the intake only, the less than fourteen day admissions and the Essenlaan T.C. group.

LASTING EFFECTS: DETOXIFICATION FROM METHADONE MAINTENANCE IN A TC

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Therapeutic communities and methadone maintenance programs view the use of medication in different ways. David Deitch (1973) has pointed out that until recently there existed a basic animosity between these two treatments, even though together they account for 43% of the people in drug treatment in the United States (Vischi, Jones, Shank, and Lima; 1980). Therapeutic communities grew out of a self-help model that viewed drug dependence as undesirable, even when the drug was a medication prescribed by a treatment program. Professionally dominated methadone maintenance programs, on the other hand, viewed the medication-free stance of the therapeutic community as closed-minded and unrealistic. Cooperation has developed slowly, as therapeutic communities have begun to recognize the uses of medication, and graduates of therapeutic communities broke down staff prejudice by working in maintenance programs. In the methadone program at which this project was based, for example, three of seven clinic counselors gained their drug treatment experience in the therapeutic community movement.

Not until 1979 did the first report appear on the role of a therapeutic community as a way for maintenance clients to achieve detoxification (Kaufman, 1979). Kaufman documented the detoxification of 94 to 215 admissions (44%) at the Su Casa therapeutic community. Although Kaufman presented little follow-up information, methadone detoxification in a therapeutic community clearly shows promise as one of several areas in which these two treatments can collaborate (Sorensen, Deitch, and Acampora, 1984). Marsha Rosenbaum has called methadone detoxification an "arduous task", which is made more difficult by the presence of models of failure in the methadone clinic (Rosenbaum and Murphy, 1984). Kuncel (1981) has reported that more intensive counseling in maintenance can be associated with lowering of methadone dosage, and the need for post-detoxification milieu support is clear (Milkman, Metcalf, and Reed, 1980); presumably the intense treatment offered in a therapeutic community could help methadone patients to detoxify and remain abstinent.

At the 1981 World Conference Acampora and Nebelkopf presented an approach used by Walden House that enabled people on methadone maintenance to detoxify in a therapeutic community (Acampora and Nebelkopf, 1983). At the 1983 World Conference our group presented preliminary results for 28 people who entered Walden House with the goal of detoxifying, indicating that 46% achieved detoxification and, upon terminating from the research project, were improved in several areas of functioning (Sorensen, Acampora, and Deitch, 1984). A subsequent publication documented the clinical methods that were used, including the preparation necessary for maintenance clients to enter a therapeutic community, the treatment regime, and the collaboration needed between the therapeutic community and the methadone maintenance clinic to bring about successful treatment (Sorensen, Acampora, and Iscoff, 1984, reprinted in this volume).

Evaluations of effectiveness in therapeutic communities have been hampered by the use multiple indicators of success, for example, decreased criminal activity, less drug abuse, and more employment. George De Leon has pointed out that these multiple measures of outcome tend to obscure the association between treatment and the person (De Leon, Wexler, and Jainchill, 1982). For example, they may show changes across clients, but they can mask the changes that individuals make while in treatment. Further, the use of multiple measures in a study takes advantage of chance associations.

These issues molded the follow-up study that we are reporting here. We summarize follow-up results with the entire sample of 32 clients who entered the maintenance to abstinence project of Walden House. To our knowledge this is the first report of follow-up information on clients who entered a therapeutic community to taper from methadone maintenance, and it uses composite measures as the key indicator of outcome.

METHOD

The Sample

Background and treatment characteristics of the first 28 subjects have been reported previously (Sorensen, Acampora, and Deitch, 1984); characteristics for the complete sample of 32 subjects appear in Tables 1 and 2. The group that entered Walden House was predominantly male (81%), White (69%), and on the average in their late twenties to early thirties. Nearly half were on probation or parole. Most had started using heroin in their late teens and had been using narcotics for an average of 13 years. They were admitted to the therapeutic community on a mean methadone dose of 37 mg and had been on methadone maintenance for an average of 27 months. About half (53%) were in their second, third, or fourth time on methadone maintenance, and about half (53%) had been in a therapeutic community before. In summary, this was a group with considerable treatment experience.

Table 1

Background of Subjects Entering the Therapeutic Community
N = 32

Sex (percent men)	81
Age in years (men)	33.0
20-29 (percent)	44
30-39 (percent)	50
40-49 (percent)	6
Ethnicity (percent)	
White	69
Black	13
Hispanic	6
Asian	9
American Indian	3
Employment (percent unemployed)	78
Education (percent high school graduate)	66
Marital status (percent married)	22
Oobation or parole (percent)	44
Court case pending (percent)	31
Age of first heroin use (mean years)	17.7
Years since first daily heroin use (mean)	12.7

Background of Subjects Entering the Therapeutic Community
N = 32

Living situation prior to therapeutic community (percent)	
Alone	22
With parent or relative	19
With spouse or lover	38
With roommate or friend	16
Jail or prison	3
Other	3

Table 2

Treatment Characteristics of Subjects
Entering the Therapeutic Community
N = 32

Time on methadone (mean months)	26.8
Less than 1 year (percent)	40
1 to 3 years (percent)	43
3.1 to 6 years (percent)	10
6.1 to 11 years (percent)	7
Dosage at intake (mean milligrams)	36.5
1-30 mg (percent)	28
31-40 mg (percent)	44
41-60 mg (percent)	28
Prior therapeutic community treatment (percent)	53
Prior alcohol treatment (percent)	23
Prior methadone maintenance treatment (percent)	53
Prior drug treatment admissions (mean)	5.6

Techniques of Locating Subjects

Subjects were located primarily from information given to the project during their treatment. At study intake each subject was approached to give permission to be followed up; each was asked to provide the names, phone numbers, and addresses of at least two people who would always know where they were living, in addition to the address and phone number of the place where they anticipated living at follow-up. Periodically during treatment in the therapeutic community and at termination subjects were reminded of the research project's desire to locate them for follow-up, no matter how things were going, as a way to evaluate the effectiveness of this kind of treatment. We updated telephone numbers and addresses throughout the treatment process. At the time of follow-up these leads were followed first. If the project was unable to locate subjects through these methods, a paraprofessional staff member attempted to locate them through street contacts.

The Instruments

The follow-up protocol used a structured questionnaire that surveyed the life situation of the subjects since their previous interview. The survey contained 53 questions with multiple choice or scaled ratings that focused on seven general areas: (1) family life/living situation, (2) legal problems, (3) income/employment, (4) social supports, (5) drug use, (6) treatment after termination, and (7) overall functioning. Following the interview the staff member made global ratings based on the information gathered in the follow-up interview and any information gathered in locating the subject. These ratings covered the most usual level of functioning for the subject in the months since the last interview. Ratings were made on a four-point scale from "poor functioning" (1) to "good or excellent functioning" (4) on six scales: Family life/living situation, living within the law, health, employment/education, substance abuse, and considering everything known. These global ratings were identical to rating items made at study entry and at termination from the research project. A final rater judgment of response accuracy indicated whether the information gathered in the interview was very reliable, acceptable, or of questionable reliability. If questionable, the rater indicated which items were in question and why. Questionable items were treated as missing data in the analysis.

At the end of the interview the subject was asked to provide a urine sample, which was collected under observed conditions. Samples were tested for nine drugs of abuse, using the thin-layer chromatography technique, by a laboratory licensed for such testing by the State of California.

Subjects reported alcohol intake by summarizing the number of cans of beer, ounces of wine, and ounces of liquor consumed in the last week. To arrive at an acceptable method of determining the amount of alcohol they drank, as opposed to alcoholic beverages of varying strengths, we devised an algorithm that calculated the amount of alcohol in each type of drink. This involved multiplying the number of beer cans drunk by .6 ounces, the number of ounces of wine by .12, and the number of ounces of liquor by .4. The total ounces of alcohol were then summarized for the week.

Creation of Composite Functioning Scores

The data analysis strategy was to investigate the use of interviewer summary ratings as a key indicator of functioning. To assess the accuracy of summary ratings, these were compared with subjects' responses to specific questions within the follow-up interview. Interviewer evaluation of clients' living situations correlated .58 with subjects' satisfaction with their living situations. Interviewer and subject ratings of legal problems corresponded closely (t = -2.43 pooled variance estimate, 4 df, p <.05,) as did their ratings of employment (t = -5.26 pooled variance estimate, 24 df, p = .001). Interviewer ratings of substance abuse corresponded closely with subjects' self-disclosure of their usage of heroin (t = 2.16 pooled variance estimate, 24 df, p < .05) and their alcohol intake (t = 1.96 pooled variance estimate, 24 df, p = .06). Interviewer ratings of substance abuse corresponded closely with the clients' report of using or not using drugs (t = 3.52 pooled variance estimate, 24 df, p < .005). Interviewer global ratings correlated .71 with subjects' global self ratings.

The pattern of intercorrelations suggested that these items were measuring related, but varying aspects of global functioning. The ten intercorrelations of subject ratings ranged from .10 to .69. The six interviewer summary ratings correlated more closely with each other (Pearson's r ranged from .56 through .88).

The high intercorrelation of the interviewer ratings, coupled with their acceptable correspondence to specific information provided by subjects, justified their choice as the source of a composite indicator of functioning. The six interviewer summary ratings were added together to create a composite functioning score. Correlations of the six summary ratings with the composite score ranged from .85 through .98.

RESULTS

Achievement of Detoxification

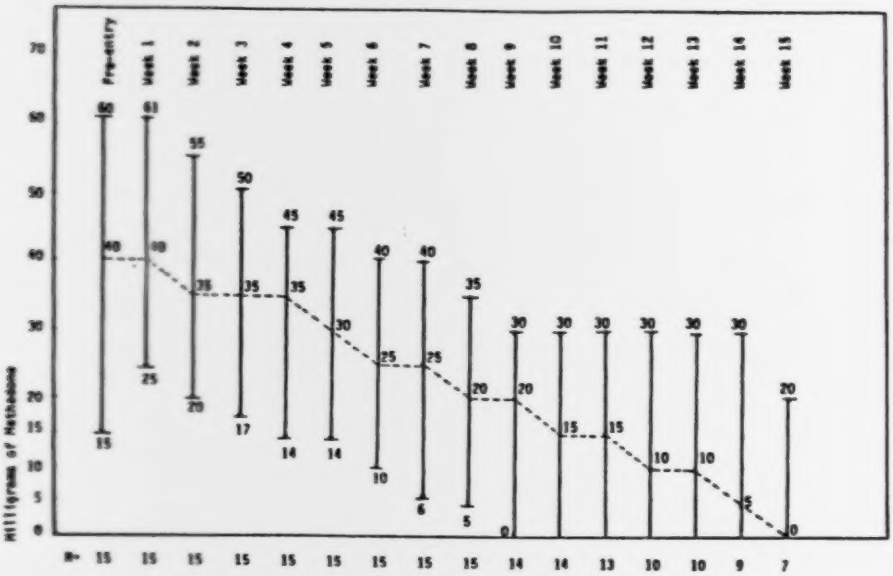
As previously reported (Sorensen, Acampora, and Deitch, 1984), 13 of the first 28 subjects detoxified from methadone at Walden House; when the entire sample of 32 subjects was included, 17 (53%) detoxified. Figure 1 presents the median dosage for the subjects who detoxified from methadone in Walden House. Generally the subjects initially stabilized their dosage, then reduced their dosage gradually to 0 mgs. The most typical pattern was dose reduction of approximately 10 mgs per month.

Follow-up Outcomes

Of the 32 subjects, one had died before the time for follow-up, one withdrew his consent for follow-up, and one stayed only three days in the therapeutic community and was not approached for follow-up consent. Of these 29 subjects, 26 were reached for at least one follow-up interview (90%), and three could not be located. The original plan had been to conduct follow-up interviews three months, six months, and one year after termination. The project did not achieve this goal, with 14 interviews occurring 0-6 months after termination, 12 interviews 7-12 months after termination, and 13 interviews occurring 13-24 months after termination. Given the small numbers of subjects reached in each follow-up period, we used the last followup with each subject as the indicator of long-term outcome. These interviews ranged from 4-24 months

Figure 1: Median Methadone Dose and Range for Subjects Who Detoxified

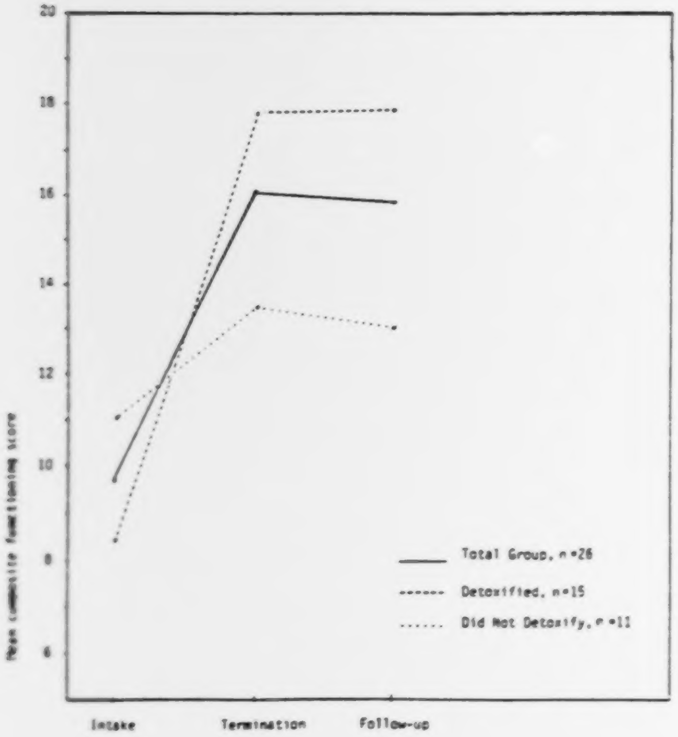
N = 17*



*Dose records are unavailable for 2 of 17 subjects

Figure 2

Mean Composite Functioning Scores For Subjects



after termination, with a mean of 12.0 months and a median of 13.0 months after termination from the research project.

Living situation at followup.

When summarizing their living situation at followup, 19 subjects rated it as better than before entering Walden House, 3 as the same, and 4 as worse. Four of the 26 subjects were still living in the therapeutic community or its outpatient apartments. Three subjects admitted to living in a household with other adult addicts using heroin. Ten were either on probation or parole, as compared with seven at entry. At followup, three had legal cases pending, compared with seven at entry. Twelve subjects were either working or in a full-time educational program at followup, compared with seven at entry into the therapeutic community.

Seven admitted to abusing drugs of some kind (opiates, stimulants, depressants, etc.) at the time of followup, compared with 20 at entry into the therapeutic community. This included five who admitted continued opiate use at followup, compared with six at entry. Eleven admitted to use of alcohol at followup (range = 1-45 ounces per week, mean = 5.3 ounces), compared with 14 of the 26 at entry (range = 1-95 ounces per week, mean = 13.5 ounces).

Comparison of pre, termination, and follow-up functioning.

Composite functioning scores revealed significant differences between entry into the study and termination (mean pre score = 10.5, mean termination score = 16.1, t = -5.03, 23 df, $p < .001$) and between entry into the study and followup (mean follow-up score = 15.4, t = - 3.61, 23 df, $p < .01$). The functioning of subjects at followup did not differ from functioning at termination (t = 0.46, 23 df, ns).

The components of the composite functioning score were examined to determine areas of change in subjects' functioning between study entry and followup. These analyses revealed significant improvement in subjects' family life/living situation (t = -2.79, 23 df, $p < .05$), employment/education (t = -2.87, 23 df, $p < .01$), substance abuse (t = -4.65, 23 df, $p < .001$), and overall functioning considering everything known (t = -4.40, 23 df, $p < .001$).

In an effort to determine whether poorly-functioning subjects dropped out of the followup early, the subjects were divided into two groups: Those subjects whose last followup occurred within one year of termination and those subjects whose last followup occurred after one year of termination. The groups did not differ on interviewer ratings of composite functioning.

Functioning of Subjects Who Completed Methadone Treatment Versus Those Who Did Not

Previously we reported staff's global ratings at termination, which revealed that those who completed detoxification were functioning significantly better than those who did not detoxify (Sorensen, Acampora, and Deitch, 1984). The follow-up results indicated that these differences endured. Figure 2 illustrates the relationship between the composite functioning of subjects who detoxified versus those who did not, at intake, termination and follow-up. The groups differed in change from intake to termination and in change from intake to follow-up; in both cases those who detoxified showed more positive change.

DISCUSSION

Overall, 53% of the subjects who entered the therapeutic community completed detoxification from methadone. The subject group showed improvement in functioning, as revealed in composite rater evaluations, especially those who detoxified from methadone. The gains lasted to the time of followup. These results are encouraging, in that they provide an example of successful collaboration of a therapeutic community with a methadone maintenance program. William Hargreaves (1983) has commented that "we still do not have the evidence that maintenance is a treatment that can increase the probability of eventual abstinence" (p. 69). Although the lack of comparison groups in the present study does not provide evidence to refute this claim, the present results indicate that the collaboration of therapeutic communities and maintenance programs may provide a way to improve the outcome of maintenance treatment for those clients who are willing to enter a therapeutic community.

The study is limited in several ways. First, this is only the second study of detoxification from maintenance in a therapeutic community, and the first to provide consistent followup information. The followups were relatively short, and varying in length of time since termination. Future investigations should should employ longer followup.

The current project, however, established that there can be a rich commerce of ideas and people between these two types of drug treatment programs. It led to our current attempt to use therapeutic community principles in an outpatient tapering and aftercare program, staffed principally by paraprofessionals who graduated from a therapeutic community. That study is currently underway.

In closing, it is important to point out that medications such as methadone may have their place in therapeutic community treatment. Lamberti and Blyth (unpublished data) point out that it is highly therapeutic to teach that the healthier family members in a therapeutic community can look out for and make concessions for the not-so-healthy. In this way the antisocial personality learns care, concern, and sensitivity, while the more fragile person benefits from the structured environment that is needed to stabilize. The inclusion of patients on methadone and other medications expands scope of the therapeutic community scope to encompass a new group of potential residents.

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CIRCUMSTANCES, MOTIVATION, READINESS & SUITABILITY: DO THESE FACTORS RELATE TO TREATMENT TENURE IN THERAPEUTIC COMMUNITIES?

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ABSTRACT

Research has convincingly demonstrated that successful outcomes in TCs are related to length of stay in treatment. However, little is known about the factors that predict which people will stay in treatment. Clinical experience suggests that the differences between those who drop out and those who remain in TCs are reflected in such factors as motivation or readiness for treatment.

A 52-item instrument was developed to measure circumstance (pressure), motivation, readiness and suitability for therapeutic community treatment. This instrument (the CMRS) is routinely completed in Phoenix House within 72 hours of admission. This paper reports preliminary findings on CMRS profiles obtained on all admissions to Phoenix House across a 4-month period. Results describe the differences in the CMRS by age, sex, race, primary drug of abuse and time in program. Findings indicate that motivation, pressure, readiness and suitability are predictive of retention in residential treatment. The CMRS appears to be a promising tool for assessing client differences, particularly for appropriate assignment to residential or non-residential treatment.

INTRODUCTION

The most consistent predictor of successful outcome in therapeutic communities has been length of stay in treatment. Nevertheless, most admissions to TCs leave before treatment benefits are evident.

Indeed, dropout is the rule across all drug treatment modalities. However, little is known about who the dropouts are, much less why they leave treatment. No client profile has emerged that correlates with length of stay in therapeutic communities. Moreover, studies fail to yield strong predictors of dropout in any treatment modality.

The fact that retention is difficult to predict from client characteristics suggests that the population studied (drug abusers seeking treatment) are, not unexpectedly, more similar than different. Hence, measures of their characteristics tend to show relatively low variability.

Nevertheless, even those who seek treatment could be diverse in ways that have not yet been fully explored. These presumed differences reflect not who clients are, in terms of fixed background characteristics, but how they perceive themselves, their circumstances, and their life options at the time of treatment involvement. Assessment of these differences could focus upon at least factors which alone, or in combination, affect dropout:

(1) CIRCUMSTANCES (extrinsic pressures): These refer to the external conditions that drive people into treatment but do not necessarily reflect inner reasons for changing oneself. External pressures may include: Losses (e.g., social-personal relationships, family support, job, school status, children, money, etc.); Fears (e.g., jail, injury, violence, health risks, suicide or death from overdose).

(2) MOTIVATION (intrinsic pressures): These refer to the individual's own inner reasons for personal change. Such reasons may be: Negative (e.g., their acceptance of drug use and other adjustment problems as serious; their experience of guilt, self-hatred or despair; their fatigue with drug use and drug related lifestyle); and/or, Positive (e.g., their wish to make a new lifestyle, their belief that they can be successful, and have the good things in life; their desire for personal growth, to be a better person, parent, spouse or mate, etc.)

(3) READINESS: This refers to the individual's perceived need for any treatment to assist in personal change, compared with alternative options. Individuals can be motivated to change but may not see the

necessity for treatment in the change process. They may favor non treatment alternatives such as: Self Change (e.g., directing themselves to be in control, manage their problems on their own); Other Options (e.g., help through friends, relationships, religion, employment, geographical relocation, etc.).

(4) SUITABILITY: This refers to the appropriate match between the individual and a particular treatment modality, such as the therapeutic community. An individual may be motivated and ready for treatment but may not be appropriate for the TC. Suitability is indicated by the individual's acceptance of the TC approach; its goals and philosophy (e.g. abstinence, socially productive lifestyle, self help and psychological growth); its regime (e.g. community living, lack of privacy, cardinal house rules, rational authority, few traditional professional staff, peer management); its, methods (e.g. resocialization, work therapy, full participation in groups and meetings, and willingness to interrupt life and relationships and make a long term commitment). Suitability is also evident in the individual's rejection of or exhaustion with other treatment options or modalities.

The relevance and clinical utility of these 4 factors are currently being investigated as part of ongoing research at Phoenix House on the problem of retention. The focus of this work is upon short term (30 days) retention since this is the period of highest attrition in all drug treatment modalities. For TCs in particular, approximately half of all dropouts leave within the first 30 days of admission (see figure 1). The present paper reports preliminary findings on the relationship of the 4 CMRS factors to short and longer term retention.

PROCEDURE

A fifty-two item instrument was developed to measure circumstance, motivation, readiness and suitability for therapeutic community treatment (The CMRS). The items were provided by clinical staff who as recovered substance abusers were asked to write down their memory of the factors associated with their entering or remaining in treatment; and by new admissions and senior residents in treatment whose word for word expressions concerning their reasons for entering or remaining in treatment were recorded by the investigator after informal interview.

A measure of the face validity of the items in terms of their reflecting the four dimensions of the CMRS was obtained through judges' ratings. All 52 statements were circulated to 11 staff members (clinical and administrative) who independently rated the degree to which items reflected the 4 dimensions as defined above; all obtained high concordance ratings.

The format of the CMRS is a self report instrument with items stated in first person and responses ranging on a five point Likert-type scale from strongly disagree to strongly agree. The CMRS was implemented as part of a general battery of tests in October, 1984 and since then has been routinely completed at Phoenix House on all admissions within 48 hours of their entry into residential treatment.

RESULTS

Preliminary findings are reported from two analyses. The CMRS correlates of short term dropout (30 days) on all admissions across an 8 month period (October, 1984 - May 31, 1985: N=400); and correlates of short and long term dropout (150 days) on a smaller cohort of admissions (October, 1984 - December, 1984: N=75).

Table 1 displays the significant correlation coefficients between the CMRS items and demography and primary drug. Circumstances (external pressures) did not appear to be a significant correlate of these variables with the exception of sex. Males more often came to treatment under pressures, legal, family, or from relationships. Most correlations occurred with age followed by primary drug, race and the fewest with sex. Generally, lower motivation, readiness and suitability for treatment appeared to be associated with younger clients, whites and primary marijuana abusers. However, interpretation of this large number of significant coefficients awaits clarification from further analyses, particularly of the intercorrelation among the CMRS items.

CMRS Correlates of Short Term Dropout

Table 1 indicates that 19 of the 52 CMRS items (36.6%) were significantly correlated with 30 day retention. None of the items were from the area of circumstance, 4 were in the area motivation and the remainder were in the areas of readiness and suitability. These results indicate that rather than external pressure (e.g. family or legal circumstances) motivation, readiness and suitability for residential treatment appear as correlates of short term retention.

Phoenix House

TABLE 1

ADMISSIONS OCTOBER 1, 1984 - MAY 31, 1985
N < > 400
CORRELATIONS OF CIRCUMSTANCE, MOTIVATION,
READINESS & SUITABILITY VARIABLES WITH
DEMOGRAPHY, PRIMARY DRUG, AND RETENTION

	Sex	Age	Black	White	Hisp	Heroin	Coca.	Marij	PCP	30 Days TIP
Circumstance										
C1. (sure I would go to jail)	-.18***	-	-.15**	.10*	-	.21***	-.14**	-	-	-
C2. (afraid of being in jail)	.16**	-	-	-	-	-	-	-	-	-
C3. (would have come without legal pressure)	-	-	-	-	-	-	-	-	-	-
C4. (family pressure to get help)	-	-	-	-	-	-	-	-	-	-
C5. (family would not let live at home)	-	.17***	-	.11*	-	-	-	-	-	-
C6. (rel. will leave if don't come into tr.)	-.18***	.10*	-.11*	.11*	-	-	-	-	-	-
C7. (rel. will try to make me leave tr.)	-	-	-	-	-	-	-	-	-	-
C8. (sure rel. will stay with me until comple.)	-	-	-	-.11*	-	-	-	-	-	-
C9. (will have serious money problems if I stay)	-.14	-	-	-	-	-	-	-	-	-
C10. (many outside problems will prevent comple.)	-	-	-	-	-	-	-	.12**	-	-
C11. (don't need tr., here because of pressure)	-	-.18***	-.13**	-	-	-	-	-	-	-
Motivation										
M1. (would have come without family pressure)	-	.16**	.12**	-.13**	-	-	.11*	-	-	-
M2. (will stay even if rel. wants me to leave)	-	.11**	-	-	-	-	.10*	.11*	-	.11*
M3. (my drug use is a very serious problem)	-	.17***	-	-	-	.14**	-	-.18***	-	.13**
M4. (drug use has caused variety of problems)	-	.12**	-	-	-	.10*	-	-.14**	-	-
M5. (can get life together even if use drugs)	-	-.13**	-	-	-	-.15**	-	-	-	-
M6. (have to stay off drugs to get what I want)	-	.10*	-	-	-	-	-	-	-	.13**
M7. (often don't like myself because of drugs)	-	.19***	-	-	-	-	-	-.12**	-	.11*
M8. ("getting high" is no problem for me)	-	-.13**	.10*	.10*	-	-.19*	.15**	-	-	-
M9. (lately, I feel I can't control my life)	-	.10*	-	-	-	-	-	-	-	-
M10. (feel I've lost everything due to drugs)	-	.24***	-	-	-	.13**	-	-.12**	-	-
M11. (if I don't change, life will get worse)	-	.16**	.11*	-	-	-	-	-.18***	-	-
M12. (afraid I'll end up dead if I don't stop)	-	.14**	-	-	-	-	-	-.16**	-	-
M13. (will have to make real changes)	-	-	-	-	-	-	-	-.14**	-	-
M14. (feel bad about hurting people)	-	.10*	-	-	-	-	-	-.19***	-	-
M15. (more imp. than anything else is to stop)	-	.14**	.13**	-.21***	-	-	-	-	-	.10*
M16. (life is ok, but have to make some changes)	-	.10*	.11*	-.18***	-	-	-	.12*	-	-
M17. (need help in areas other than drugs, also)	-	-	-	-	-	-	-.10*	-	-	-

	Sex	Age	Black	White	Hisp.	Her.	Coc.	Mar.	PCP	30 Days TIP
Readiness										
R1. (don't need treat.,can stop if I want)	-	-.11*	-	-	-	-	-	.11*	-	-.18***
R2. (came to PH because ready to deal w. myself)	-	.13*	.23***	-.18***	-.10	-	-	-	-	.15**
R3. (will do whatever I have to)	-	-	-.16***	-.12**	-	-	.11*	-	-	.10*
R4. (see no other choice for help except treat.)	-	.18***	-	-	-	-	-	-.13**	-	.14**
R5. (can't stop drugs with S.O. or religion)	-	.13**	-	-	-	.10*	-	-.14**	-	-
R6. (if can't get help here, will go elsewhere)	.10*	.24***	.17***	-	-.13**	-	-	-.12**	-	.10*
R7. (tired of drugs, know can't change on own)	-	.20***	-	-	-	.10*	-	-.12**	-	.17**
R8. (willing to enter treat. soon as possible)	-	-	-	-	-	-	-	-	-	
Suitability										
S1. (willing to sever family ties for a while)	-	.15**	.13**	-.10*	-	-	-	-	-	-
S2. (willing to sever street ties for a while)	-	.18***	-	-	-	-	-	-.11*	-	.12**
S3. (PH type of program seems right approach)	-	-	.11*	-.11*	-	-	-	-.12**	-	.23***
S4. (need long period in new environ. to change)	-	-	.10*	-.15**	-	-	-	-.14**	-	-
S5. (need to change attitude as well as behav.)	-	-	-	-	-	-	-	-	-	-
S6. (need to be drug free to live success.)	-	.13**	-	-	-	-	-	-	-	-
S7. (don't think can adjust well to PH)	-	-.13**	-	-	-	-	-	-	-	-.15**
S8. (some other kind of treat. more helpful)	-	-	-	-	-	-	-	-	-	-
S9. (means a lot of sacrifice to stay)	-	-	-	-	-	-	-	-	-	-
S10. (don't feel my problems serious enough for PH)	-	-	-	-	-	-	-	.11*	-	-.14**
S11. (will stay in PH as long as I have to)	-	.13**	-	-.12**	-	-	-	-.16**	-	.18***
S12. (drug use is only part of my problem)	-	-	-	-.10*	-	-	-	-	-	.13**
S13. (have to avoid people & places with drugs)	-	-	-	-	-.12**	-	-	-	-	-
S14. (have tried other treat.,hasn't helped much)	-.16**	.11*	-	.12**	-	-	-	-	-	-
S15. (can't help myself at home; need to be in PH)	-	.12**	-	-.24***	-	-	.10*	-.24***	-	.21***
S16. (have fears about being in place like PH)	.16***	-	-	-	-	-	-		-	-

* p .05
** p .01
*** pp .001

PHOENIX HOUSE

TABLE 2

COHORT I: SINGLE ADMISSIONS OCTOBER 29, 1984 - DECEMBER 17, 1984

CORRELATIONS OF CIRCUMSTANCE, MOTIVATION,
READINESS & SUITABILITY VARIABLES WITH
DEMOGRAPHY, PRIMARY DRUG, AND RETENTION

N< > 75

	Sex	Age	Black	White	Hisp	Heroin	Cocaine	Mari	PCP	30 day TIP	90 days TIP	150 days TIP
Circumstance												
C1. (sure I would go to jail)	-	-	-	-	-	.29***	-	-	-	.22**	.28**	.27**
C2. (afraid of being in jail)	.20*	-	-	-	-	-	-	-	-	-	-	-
C3. (would have come without legal pressure)	-	-	-	-	-	-	-	-	-	-	-	-
C4. (family pressure to get help)	-	.18*	-	-	-	-	-	-	-	-	-	-
C5. (family would not let live at home)	-	-	-	.18*	-.17*	-	-	-	-	-	-	-
C6. (rel. will leave if don't come into tr.)	-.22**	-	-	-	-	-	-	-	-	-	-	-
C7. (rel. will try to make me leave tr.)	-	-	-	-	-	-	.26**	-	-	-	-	-
C8. (sure rel. will stay with me until comple.)	-	-.22**	-	-	-	-.18*	-	-	-	-	-	-
C9. (will have serious money problems if I stay)	-	-	-	-	.24**	-	-	-	-	-	-	-
C10. (many outside problems will prevent comple.)	-	-	-	-	.20*	-	-	-	-	-.23**	-.27**	-.25**
C11. (don't need tr., here because of pressure)	-	-.20*	-.28***	-	-	-	-	-	-	-	-	-
Motivation												
M1. (would have come without family pressure)	-	-	.20*	-	-	-	-	-	-.23**	-	-	-
M2. (will stay even if rel. wants me to leave)	-	-	.18*	-	-	-	-	.31***	-	-	-	-
M3. (my drug use is a very serious problem)	-	.26**	.18*	-	-	-	-	-	-	-	-	-
M4. (drug use has caused variety of problems)	-	-	.21*	-	-	-	-	-.17*	-	-	-	-
M5. (can get life together even if use drugs)	-	-.27**	-	-	-	-	-	.19*	-	-	-	-
M6. (have to stay off drugs to get what I want)	-	-	-	-	-.25**	-	-	-	-	.28**	.25**	.28**
M7. (often don't like myself because of drugs)	-	.19*	-	-	-	-	-	-	-	-	-	-
M8. ("getting high" is no problem for me)	-	-.26**	.25 **	-.18*	-	-.30***	.28***	-	-	-	-	-
M9. (lately, I feel I can't control my life)	-	-	-	.20*	-	-	-	-	-	.21*	-	-
M10. (feel I've lost everything due to drugs)	-	.33***	-	-	-	-	-.19*	-	-	-	-	-
M11. (if I don't change, life will get worse)	-	-.23**	.38***	-.23**	.20*	-	-	-	-	-	-	-
M12. (afraid I'll end up dead if I don't stop)	-	.23**	.23 **	-	-	-	-	-	-	-	-	-
M13. (will have to make real changes)	-	-	-	-	-.22**	-	-	-	-	-	-	-
M14. (feel bad about hurting people)	.18*	-	-	-	-	-	-	-	-	-	-	-
M15. (more imp. than anything else is to stop)	-	.27**	.25**	-.22**	-	-	-	-.22**	-	.21*	-	-
M16. (life is ok, but have to make some changes)	-	-	-	-.22*	-	-	-	.21*	-	-	-	-
M17. (need help in areas other than drugs, also)	-	-	-	-	-	-	-	-	-	-	-	-

	Sex	Age	Black	White	Hisp	Heroin	Coca	Marij	PCP	T I P(days) 30	90	150
Readiness												
R1. (don't need tr., can stop if I want)	-	-.20*	-	-	-	-	-.21*	.27**	-	-.30***	-.29**	-.27**
R2. (came to PH because I'm ready to deal w/myself)	-	.31***	.53***	-.25**	-.36***	-	.24**	-.25**	-	-	.22**	.21*
R3. (will do whatever I have to)	-	.18*	.37***	-	-.27**	-	.18*	-.24**	-	-	.23**	.22**
R4. (see no other choice for help except tr.)	-	.32***	.26**	-.19*	-	-	-	-.22**	-	.19*	.19*	.19*
R5. (can't stop drugs with S.O. or religion's help)	-	.24**	-	-	-	-	-	-.27**	-	.30***	-	.30**
R6. (if can't get help here, will seek it elsewh.)	-	.30***	.22**	-	-	.18*	-	-.20*	-	-	-	-
R7. (tired of drugs, know I can't change on own)	-	-	.20*	-	-	-	-	-	-.19*	-	.19*	-
R8. (willing to enter tr. as soon as possible)	-	-	-	-	-.18*	-	-	-	-	.26**	.25**	.20**
Suitability												
S1. (willing to sever family ties for a while)	-	.39***	.37***	-.33***	-	-	-	-.38***	-	-	.19*	-
S2. (willing to sever street ties for a while)	-	.40***	.28**	-	-.19*	-	-	-.21*	-	-.25**	.21*	-
S3. (PH type of prog. seems to be right approach)	-	-	.27**	-	.18*	-	-	-	-	.40***	.41***	.39***
S4. (need long period in new env. to change)	-	-	.40***	-.31***	-	-	-	-	-	-	-	-
S5. (need to change attit. as well as behav.)	-	-	.30**	-.28 **	-	-	-	-	-	-	-	-
S6. (need to be drug free to live successfully)	-	-	.20*	-.25**	-	-	—	-	-	-	-	-
S7. (don't think I can adjust well to PH)	-	-.18*	-.22**	-	.25**	-	-	-	-	-	-	-
S8. (some other kind of tr. would be more helpful)	-	-	-	-	-	-	-	-	-	-	-	-
S9. (know it will mean a lot of sacrifice to stay)	-	-	-	-	-	-	-	-	-	-	-	-
S10. (don't feel my problems serious enough for PH)	.24**	-	-	-	-	-	-	-	-	-	-	-.19*
S11. (will stay in PH as long as I have to)	-	.21*	.29**	-.22**	-	.18*	-	-.25**	-	.35***	.33***	.39***
S12. (drug use is only part of my problem)	-	-	.24**	-.35***	-	-	-	-	-	-	-	-
S13. (have to avoid people and places w/drugs)	-	-	.38***	-	-.39***	-	-	-.19*	-	-	-	-
S14. (have tried other tr. and hasn't helped much)	.19*	-	-	.20*	-.25**	-	-	-	-	-	-	-
S15. (can't help myself at home; need to be in PH)	-	.20*	.21*	.20*	-	-	.21*	-.37***	-	.24**	.21*	.20*
S16. (have fears about being in a place like PH)	-	-	-	-	-	-	-	.18*	-.21*	-	-	-

* P < .05
** P < .01
*** P < .001

CMRS Correlates of Long Term Retention

Table 2 contains the significant correlations of the CMRS items, with 30, 90, and 150 day retention for a smaller cohort of admissions. Overall, a constant 25% of the CMRS items were significant correlates of 30, 90, and 150 days retention. Focusing on long term (150 days) retention, 2 of the items were in the circumstantial area, 1 from motivation and the remainder were in the areas of readiness and suitability.

The results in Table 2 indicate that the same CMRS items persisted as correlated of both short and long term dropout. For example, most of the significant CMRS correlated of 30 day retention remained significant for 90 and 150 day retention; the others were the same correlates of 2 points in time. Thus, about a quarter of the CMRS items were significantly correlated with short term retention, practically all of which were persistent correlates of longterm retention.

DISCUSSION

Although preliminary, the present findings are impressive in showing a consistent association between self report statements that purportedly measure motivation, readiness, or suitability for therapeutic community treatment and short and long term dropout. Thus, the CMRS appears to have clinical utility since it has potential for identifying clients who are "at risk" for early dropout. Although such high risks clients may hot necessarily be screened from treatment, they can be better prepared for the therapeutic community experience during the admission process or in their orientation phase. Clinicians can be alerted to focusing on such issues of denial (motivation), reducing resistance to treatment (readiness), and role induction (suitability).

The CMRS also has implications for research and theory. For example the present results accord with the perspective on retention elaborated in other writings (e.g. De Leon, 1984) and outlined in the introduction to this paper. Briefly, retention in treatment reflects a complexity of factors, related to the client, treatment and non-treatment conditions. With respect to the client factors, however, the present results emphasize the importance of how clients see themselves and their options during their involvement with treatment. Perception of the severity of their problems, needs for treatment and their acceptance of particular treatment alternatives appear to directly relate to their tenure in treatment.

These perceptual factors, however, may be linked to "fixed" client characteristics such as those associated with age. For example, in this and in previous research, age is not a predictor of dropout, although age is known to correlate with length of addiction, fatigue with the drug lifestyle and attempts to stop drug usage. The present results indicated that motivation, readiness and suitability, correlated with both age and dropout. Thus, rather than age alone, these age associated characteristics may lead to changes in motivation and readiness which in turn correlate with retention in treatment.

That the CMRS correlates of short and long term retention were the same items remains to be explained. For example, research has established that the longer clients remain in treatment the greater the likelihood that they will continues to remain in treatment (e.g. De Leon and Schwartz, 1984). This likelihood of staying in treatment somewhat clouds the specific contribution of the CMRS factors to long term retention. Perhaps initial readiness and suitability are correlated with short term treatment, after which program influences combine with or enhance these factors to sustain longer term retention in treatment. This hypothesis is currently under investigation in Phoenix research. However, the persistence of the CMRS factors over time may illuminate why clients drop out of treatment. For example, research indicates that short term and long term dropouts leave treatment for different reasons. (De Leon, 1984; Jainchill et al, 1985; Craig, 1984). The present findings suggest that although the explicit reasons for dropout may vary over time, these may influence, or be influenced by, motivation, readiness and suitability which appear as the consistent correlates of retention.

Given the experimental status of the CMRS, the present findings and conclusions must be interpreted with caution. The magnitude of the coefficients are low to moderate; and their was a high degree of intercorrelation among the items which suggests that the number of statements can be considerably reduced. Moreover, further analysis will clarify the independence of these four dimensions. For example, whether motivation and readiness constitute distinctly different areas is not firmly demonstrated. The present instrument is currently under revision to satisfy these issues as well as psychometric and pragmatic considerations.

Nevertheless, these orderly results obtained on a large sample of admissions confirm the widely held clinical view of the importance of motivation, readiness and suitability in successful treatment. Thus, the CMRS appears to be a promising tool for assessment, treatment planning and research in therapeutic communities.

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JUVENILE DRUG ADDICTION: A STUDY ON TYPOLOGY OF ADDICTS AND THEIR FAMILIES

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Objectives

There was a time when drug addiction was limited to a specific social group, or to individuals whose deviant behavior was already patent before they took to drugs. But now dependence on heroin (and, most recently, cocaine) involves an important proportion of the juvenile and adult population of Italy.

The relative ease of access to drugs has led to a situation in which drug dependence covers, masks, and partially compensates for a wide range of personal and family problems.

In previous papers some of us presented a tentative classification that related drug addiction to there problems. Four main categories or syndromes of drug addiction emerged:

A. Traumatic drug addiction
B. Drug addiction from actual neuroses
C. Transitional drug addiction
D. Sociopathic drug addiction

These categories grew out of research undertaken from several different approaches: a) the study of the organization and the modes of communication of the families of drug addicts; b) the observation and description of the behavior of the drug addicts themselves; c) the evaluation of the personal problems of drug addicts, from a psycho-dynamic perspective; and d) the evaluation of the practical effects over time of different therapeutic strategies.

Elsewhere we have discussed the problems raised in combining data gathered using such different points of view. In this paper we will deal primarily with data derived from a population of 103 drug addicts treated by a group of therapists with a systemic/relational approach.

We have included in this statistical population only those subjects who began treatment in 1982 and who had finished treatment (or interrupted it) by June, 1984, when the follow-up study was made.

There was no "filter" imposed on persons who made the initial request for help. Nor was it required that addicts be present at the first interview with persons involved in their problem. The interview was centered on the present situation of the addict, her/his family, friends, and previous therapies. This information was in turn presented by the therapist to a discussion group, which decided on the best approach: a) family therapy; b) individual support; c) network therapy; d) counseling focused on the possibility of getting the addict to enter a therapeutic community. In 28 cases these procedures failed (18% of the total requests for help) and the addict refused treatment. These addicts have not been included in the population studies here.

Following a decision made at the beginning of the research, two different types of family therapy were used, depending on the attitudes of the families involved. The model proposed by Haley and by Stanton and Todd (which we will refer to as "structural" family therapy) was applied when the therapists had the impression that the family reacted strongly to them and assumed a clear position in regard to the drug addiction. On the other hand, a "paradoxical" strategy was used when the therapists perceived a weak, disorganized, and confused reaction from the family, seemingly unable to take a stand in regard to the symptom and its consequences.

While the first interview was made by a single therapist, the family therapy sessions were always conducted by two therapists. On request, the team could receive the external supervision of an expert in family therapy. When necessary, drug withdrawal took place in the home of the patient, with the active involvement of the family. The therapists themselves provided the medical and psychological home support necessary in this phase. At the beginning of treatment, family therapy sessions were held weekly; and when the therapy was advanced, monthly. The therapeutic setting was flexible, and the therapists would meet with the family at the family's request if something new came up. The average length of therapy was about a year, and counseling took place in up to four sessions. The study was conducted in a private center (Albedo Center) and the cost of the therapy was partly covered by a subsidy from the Lazio Region Administration.

A research group discussed the organization of clinical, therapeutic, and follow-up data. The assignment of individual cases to the four categories of addiction was made by researchers on the basis of information provided by the therapists, using a schedule drawn up in the context of a wider study of the typology of drug addiction.

In Table 1 we have included: a) the distribution of the 103 drug addicts studies, with their families, in the four categories of the classification; b) the kind of therapeutic program adopted; and c) the outcome of the therapy.

The table shows clearly the following:

a) There is a relation between the categories of addiction and the therapies proposed; therapists employ family therapy in the addictions of type B ("actual neuroses") and C ("transitional"); offer individual support to "traumatic" addictions (type A); and organize a network therapy or assignment to a therapeutic community in the case of sociopathic addictions (type D).

b) There is a significant correlation between the cases in which the therapists decided to employ a paradoxical strategy and the cases classified as type C ("transitional"); the reasons for their decisions will become clear in the following discussion.

Traumatic Drug Addiction

The family contexts for this kind of addiction are rather varied. In some cases the patients have been "model" sons or daughters, who kept to themselves their own problems (accustomed as they were to resolving the problems of others) and gave way to addiction in the face of a serious trauma. In other cases, the patients are persons who have only recently gone through the phase of individuation or separation: the trauma threatens their equilibrium in a period in which their earlier relationships no longer provide adequate support and their new ones are still too precarious to ensure a point of reference. Such persons may be adolescents who have only recently defined their own identity or young adults not yet involved in deep relationships or only recently members of a couple, whose new network of relations in inadequate at the time of need caused by sorrow and mourning. A sense of guilt, often present in the experience of mourning, is easily linked in these adolescents or young adults to the effort of emancipation from the family nucleus in stressful circumstances.

Clinically, we can identify three elements that characterize this kind of drug addiction:

a) The way the addiction develops: whether it is the result of a first contact with the drug or the transformation in addiction of a drug use previously controlled, the break with the normal pattern of life occurs quite rapidly, and heroin suddenly becomes the center of attention, protecting the individual in a state of panic.

b) Aspects of the habit: the addict is autodestructive and theatrical, uses alcohol and barbituates in addition to heroin, seeks numbness rather than pleasure, increases dosage rapidly, and is at high risk for overdoses.

c) The importance of being in bad shape: from a certain point on, the addict may use withdrawal symptoms caused by abstinence, harm to the body causes by drug abuse, and societal disapproval to cover or mask the sense of guilt provoked by the trauma.

Note that there is no significant correlation between this kind of addiction and the kind of drug used. And that in spite of its dramatic nature, these kinds of addiction often respond well to therapy. Recovery is total if the drug has not caused permanent physical damage.

From a therapeutic viewpoint, it is fundamental to build a significant relationship with the type A addict. This relationship may be mediated, in some cases, by the prudent short or long-term use of a substitute drug. The thematization and verbalization of the mourning must be reference points of a discourse which rapidly moves from the drug to the person. It is risky, in this kind of situation, to involve

TABLE 1.

Drug addicts beginning treatment in the Albedo Center in 1982. The numbers in parentheses indicate the percentage of subjects whose improvement was stable after 18 months after the end of successful therapy.

Type of Addiction	Family Therapy Structural	Family Therapy Paradoxical	Network Therapy	Individual Therapy	Total	Counseling
Traumatic (A)			1 (100)	3 (66)	4(75)	
Neuroses (B)	49 (63)				49(63)	2
Transitional (C)	11 (36)	22 (73)			33(61)	2
Sociopathic (D)			3 (33)		3(33)	10
Total	60 (57)	22 (73)	4 (50)	3 (66)	89(67)	14

directly the original family, for by centering attention on the current conflict, it may impede the elaboration of the mourning. In our experience it is rarely necessary to have recourse to live-in therapeutic programs.

The Case of Mario. Mario began the use of heroin at age 20, a few months after the death of his father and the discovery that his older brother was seriously ill. After an initial "high" phase, a dramatic experience linked to an overdose marked both the most acute point in the addiction and the beginning of a critical reflection of his situation. Various attempts at withdrawal by means of other drugs were unsuccessful. The effective therapy began with withdrawal at a walk-in clinic using symptomatic drugs under the direct daily control of the therapist, who set up with Mario an intense, significant relationship. The second part of the therapy involved the verbalization and elaboration of the recent experience of loss. With the support of the therapist, Mario slowly began to reorganize his life: he met in a new way situations of "risk" (meetings with his addict friends, his difficulty in his relations with his fiancee, etc.) without falling back into addiction. After six years, Mario is working, leads a satisfying life, and has not gone back to drugs.

The Case of Franco. When he was 17 years old Franco was in an automobile accident and his father died in his arms in the ambulance on the way to the hospital. His drug use began within a few days and within a year Franco felt he had "touched the bottom." He succeeded in giving up drug use for three months while he lived in his girlfriend's house, but as soon as he returned home he took up heroin again The therapy began by involving Franco's mother and brother. But after three sessions in which accusations and reciprocal misunderstandings prevented the therapists from getting at the problems related to the family's recent trauma, Franco's mother did not want to come any more, and Franco himself rejected the presence of his mother and brother. A new period of total involvement with the drug led him to seek help again, and this time the therapist proposed an individual therapy. Attention was centered on the anguish caused by the violent loss of his father and his admission of a feeling of guilt for not being able to avoid the accident. These feelings had been repressed and denied for more than a year during the addiction. At the same time, the therapist provided personal support, involving the fiancee as well, to help Franco land a job through an open competition. Four years after the end of the therapy, Franco has held his job, uses heroin no longer, and has gone to live with his girl.

Drug Addiction from Actual Neuroses

Actual neurosis is characterized by the existence of active conflict around the subject that is more important than infantile conflict in defining the symptomatic description (feelings of inadequacy/incapacity, depressions, various idiosyncrasies, a waning in activity and interests, demonstrative behavior). Its reality has been questioned by some modern psychoanalysts, but its clinical presence is indisputable for those who treat drug addicts and their families.

The family structure in which this kind of drug addiction develops has been repeatedly described by family therapists who have worked with addicts. In systemic and family terms in involves:

a) the deep involvement of one of the parents (generally that of the opposite sex) in the life of the daughter/son and her/his "sickness";

b) the peripheral role of the other parent;

c) the presence of a structure known as the "perverse triangle";

d) the weakness of boundaries between the subsystems that made up the family hierarchy;

e) the development of a polarity that defines the addict child as "bad" as compared with another "good" child;

f) a system of communication characterized by contradictory (not paradoxical) messages and conflicts that develop with rapidity and violence.

There are obvious parallels between these families and those of young delinquents and of children with psychosomatic symptoms or slight behavioral problems.

From a clinical point of view, type B addictions (above all seen in the clinics where methadone is given to addicts "dissatisfied" with any kind of therapy) are depressive in nature (addicts do not obtain pleasure from drug use) and involve a demonstrative stance. Addictive behavior is alternately a pained defiance or an intolerance involving a direct provocation of those persons perceived as responsible (generally parents, but often as well the therapists and others who seek to help).

From the therapeutic viewpoint, efforts must be directed from the very start toward the control of symptomatic behavior by means of the establishment of a united front on the part of the parents and/or other adults available to help. For accurate descriptions of the problems involved with this kind of addiction and possible solutions, the work of Stanton and Todd and Alberdo may be consulted. Here we wish to note only that with this kind of intervention, it is possible to undertake the withdrawal at home.

Generally, it is useless to work individually with these addicts. Time in a therapeutic community may be decisive (although not always necessary), but only when the therapy involves both parents.

The Case of Marco . Marco's addiction involved dramatic acting out within the family: attempted suicides, thefts from home, incidents connected with the injection of the drug. His mother became so concerned that at times, after threats of suicide, it would be she who actually did the injecting. Prior to the addiction, Marco's parents had threatened to separate, and conflict was frequent in the family.

In the first phase of therapy it was decided to give the father the authority to set the rules Marco would have to obey during home withdrawal. The mother was to collaborate with the father. Marco's father, until then completely peripheral, for the first time succeeded in demonstrating his strength and taking control over his son. The therapists, called urgently to the home, witnessed an all-out struggle between Marco, who threatened to jump out the window in order to have the drug, and his father, who succeeded in not giving it and in blocking Marco's behavior. After withdrawal, the therapist began on the one hand meetings with Marco and his girlfriend (to consider setting up a new life) and on the other with his parents (to work on the marital conflict and its symptoms that appeared in the mother when the addiction of the son was under control). In the following ten years, Marco has not gone back to drugs and had led a satisfying life.

Transitional Drug Addiction (Type C)

Glover has studied drug addictions in which the defense mechanism of the addict has a typical "transitional" form. That is, the psychotic and neurotic components (especially obsessive, depressive, or paranoid) interact in a complex way and present a clinical description whose evolution is similar to other kinds of manic-depressive psychoses. This kind of addiction has the following characteristics:

a) Powerful, repeated, manic states, particularly in young heroin addicts: the addict lives a "honeymoon" and experiences sudden and pleasing effects from the drug; drug use relieves specific personal sufferings that existed long before the encounter with the drug, and which emerge in a careful enquiry; "one is struck," claims Olievenstein, "by the totalitarian description, very close to ecstasy, of the first flash... an incomparably revelation, unity obtained once more, the atmosphere of joy..."

b) Powerful, repeated, depressive states (particularly frequent and stable on adult addicts), with a corresponding ritualistic, compulsive, destructive, and obtuse addictive behavior: importance is placed on the need to be continually numbed, rather than on the pleasure by the effects of the drugs consumed;

c) overall, difficulty on the part of patients, their parents, or outside observers in linking the evolution of the addiction to specific events in the life of the addict; it is not unusual, for instance, for the habit to have begun "when things were going well" or for it to be interrupted when damage to the body or specific pains take over from the negative effects of the drug;

e) a long-term risk of backsliding, sometimes in the form of alcoholism, on the part of those considered "cured".

In our experience, the organization and communicative style of the families where this kind of addiction is present show interesting analogies with those of families of anorexics.

a) The effort not to define relationships is maintained by frequent (but not obligatory or continuous) use of paradoxical and incongruous messages (for instance, returning to the habit as a response to the proposal of therapy, depressive or paradoxical resistance to therapeutic sessions, etc.); there is a high level of mystification both within the family and in its contacts with the outside, which renders the information it gives of questionable value, and makes the overall atmosphere or ambiance more significant.

A detailed discussion of this argument does not seem appropriate here. We would like to emphasize, however, in reference to the connection between this kind of personal problem and the communicative dysfunction of the family, its relevance in leading one to question the point of view of parents who seen the addiction as the result of an unredeemable immaturity on the part of the child incapable of acting in her/his own best interests. It is precisely this kind of conviction or motivation, whose incongruity is matched only by the fervor by which it is maintained, that appears to inspire the two extremes of "the coercive therapeutic community" and "controlled administration of heroin", which have provoked so much controversy in recent years.

b) members show a diffuse tendency to ignore the meaning of the messages of the others and to use the illness in order to resolve the problem of leadership, taking a stance of self-sacrifice.

There are also, however, differences between these families and those of anorexics:

a) In these families there is a tendency to draw in and manipulate therapists, friends, and relatives in family matters in order to strengthen their own positions;

b) In these families there is a tendency to act out repeatedly very intense, but brief scenes (as with conflicts between parents that often end in incomplete separations).

These parents (whose relation is only sometimes that of the symmetrical "hubris" of psychotic families) are both involved in the addiction or private life of their offspring. The polarity between the sons is not that of good/bad as in type B, but rather that of success/failure. Often in this kind of family, as in those with a psychotic patient, there is a person whom Mara Selvini has called the "prestigious member": a sibling who, for a variety of reasons, enjoys a prestige in regard to brothers and sisters. This figure commonly is affectively involved in the problems of the family; feels more competent in resolving them, and has a long history of intimacy with one of the parents." At the time of detachment of the prestigious member, "the behavior of the patient, far from that of dislodging the annoying brother from a situation that had become insufferable, has the effect of fixing things as they are."

The therapist dealing with this kind of situation may try to oppose resolutely the addictive behavior, redefining it as an extreme manifestation of a more important interpersonal problem and working swiftly to control the symptoms. But in our experience, the therapist must protect against returns to drugs by taking an attitude and making redefinitions that can later be used with a paradoxical strategy.

In other cases (like that reported below), the therapist may decide to follow a paradoxical therapeutic strategy from the start.

The Case of Sandro . Age 23, Sandro has been an addict for seven years already. Recourse to methadone and other treatments had no positive effects. Three persons came to the first family therapy session: Sandro, his mother, and Lisa, his 18 year old sister. His father had died many years earlier. With an air of tragedy, the mother complained about the money her son extorted from her daily. Sandro, who did not like to talk about his addiction which he experienced "as an annulling of all thought and feeling," said that his mother did not understand him. Lisa said there was nothing she could do and talked about the repercussions on her private life of her brother's problem. The therapists, emphasizing the absence of a common goal, asked for time to think over the possibility of beginning therapy, in order not to raise false illusions. The family reacted sharply to this provocation, telephoning several times to obtain a new appointment.

The therapists decided to use a paradoxical strategy, one which included the use of "sculptures" as proposed by P. Caille. during the first session, the sculpture ought to illustrate, according to each person's point of view, what happens in their daily relations. In the second session, each person should use a "mythic" symbolic image for the trait that makes their family unique and original. The elements çproposed at this point are those to be used in the final paradoxical intervention, but in the meanwhile the therapy is based on the content of the first phenomenological sculpture. A certain number of sessions were used to discuss individually with members of the family the possibility of adding "new elements" to the normal interactions of the family. Apt suggestions accepted, but not put into practice by each family member, were used by the therapists to force each person to confront her or his incapacity for making even small changes. This facilitated a return to the elements of the "mythical" sculpture to propose the paradoxical intervention. One of the therapists explained to the family why it was better to maintain their present equilibrium without pushing for change. Even the addiction was redefined as essential for maintaining what seemed to be the system's best equilibrium. The other therapist, however, said he did not agree. Sandro, in his opinion, did not want to continue to sacrifice himself; Lisa wanted to get away from home; their mother, free of the kids, would have finally been able to think of herself. The struggle caused by this intervention lasted several months and permitted a therapy which challenged the system of the family and an acceptance of personal experience. A year after the first therapeutic session Sandro has stopped using heroin and has found a job.

Sociopathic Drug Addiction (type D)

This kind of addiction is frequently found in the kind of person who expressed psychic conflict by acting it out. Such persons typically share the following traits or histories:

a) known antisocial behavior prior to drug addiction, particularly in adolescents and young adults who live in conditions of social and cultural disadvantage;

b) a rapid and natural assimilation of drug addiction within a lifestyle adapted to drug use, but which takes on a caricature-like aspect when the habit becomes addiction;

c) the defiant attitude of the addict, who acts with the coldness and the provocation of someone "unable to love and accept love", and who sees the environment as cold and hostile, relieved only by the occasional volunteers who enter his/her life in the role of providential "saviors";

d) the detachment with which the addicts speak of their habits; the anaesthetic numbness of the sensations sought from drug use; the frequency of multiple drug-use; and the underestimation of the effects of the drug (which include permanent bodily harm).

Typically these addicts are the children of economically and culturally deprived women, who have abandoned them in the state institutions; or (often the two types overlap) children of multiproblem families in the ghettos of the big cities. The maladaptation of these youths is evident first in difficulties in school, and later, in adolescence, in the progressively increasing violence with which they react to the rules of a society perceived from their delinquent subculture as cruel and hostile. There are other cases in which economic and cultural difficulties are not so obvious.

The communicative model and organization of the families of addicts of this type resemble, in the less serious cases, those of the families of addicts due to present neuroses. But in the more serious cases the resemblance is greater with "detached" families. Such families, normally from the most disadvantaged social classes, but occasionally from middle or upper classes, are profoundly and dramatically disorganized, human groups whose members seem to move in isolated orbits without any apparent reciprocal interdependence.

Many of the more serious addicts are marked by the experience of total abandonment in early childhood, and many of the others had an early childhood marked by family problems. entional therapy are in these cases rare and difficult. Nevertheless, one notes, looking at the life histories of those addicts who have broken their habit, that it may be that the combination of a series of therapeutic spells may produce surprising results. These are, up to now, somewhat spontaneous trajectories which are worth studying. An addict who has been able to stop shooting up first went to a methadone maintenance clinic, had good rapport there with a technician, then went to conventional therapy are in these cases rare and difficult. Nevertheless, one notes, looking at the life histories of those addicts who have broken their habit, that it may be that the combination of a series of therapeutic spells may produce surprising results. These are, up to now, somewhat spontaneous trajectories which are worth studying. An addict who has been able to stop shooting up first went to a methadone maintenance clinic, had good rapport there with a technician, then went to live in a therapeutic community, which he left to join another, "more appropriate" one, and finally joined a craftsman's cooperative. An attentive study of similar stories, far from demonstrating the unusefullness of the various therapies, suggest that in these cases a "therapeutic chain" might well be organized in which more therapeutic approaches might cooperate, each one representing a significant step toward change.

The therapeutic community is particularly useful in these cases as the final stage. It (and sometimes it alone) can fill the vacuum of social and family relations, receiving the person in a group in which to deal with the anguish caused by different kinds of suffering. In some cases, special techniques aimed at the system may be applied (like those described by MacGregor for multiproblem families, and Judith Landau for disadvantaged families).

The Case of Fabio . Soon after emigrating, Fabio's father had effectively abandoned his family. His mother, who was alcoholic, had lost legal custody of her children, who had become wards of the children's' court. After growing up in various institutions, Fabio began his life in the streets. Through heroin he achieved his desire to "lose himself." He used very high doses, smoked hashish, shut himself off from the world, and became ever more depressed. He lived by stealing and was part of a group of delinquents. after a few attempts at withdrawal with methadone in a clinic, he went with a friend to a community. It was hard for him to adapt to the rules, and it was decided to make an exception in his case and relax some of the admissions requirements. At the same time he began to take part in group therapy. After two years, he succeeded in breaking the habit and in starting new life projects. At present, through still in contact with the community, he has a job and a home.

The Case of Franca. Franca, age 25, is separated and has a baby that her husband and her parents-in-law want to take away from her because of her drug addiction, which has lasted for five years. She lived for a while in a community with the child, but as soon as she left she began to shoot up again. At the same time that she approached the Albedo group for therapy, she was getting treatment at a public facility, where she had gotten several staff members concerned with her problems.

Her father, "the only person with whom I've had a good relation," committed suicide when she was seven years old. Her relations with her mother and her sister soon became difficult, and when she was sixteen she left home and never went back. She has lost all contact with her parents. She quickly sought to tie the therapist to her, using her fragility. She said she was unable to deal with any situation, and that the therapist was the only person who could save her. The therapists decided on a strategy of network therapy, involving all the persons who had had significant relations with Franca. To the session came the ex-husband, his family, some women friends, the staff members of the public clinic, and her mother and her sister, called in for the occasion froma foreign country. The support offered to Franca on this occasion made it impossible for her to continue to manipulate the therapist and hide herself behind the mask of fragility and loneliness. She had serious problems to face (her husband had files for custody of their child; she had no job, no house, etc.).

In this way an individual psychotherapy began aimed at facing one by one the problems involved with the different steps Franca would have to take to reorganize her life. After a year she had gotten a job and a house.

Discussion

From the point of view of family therapy, the classification we have proposed leads to several simple suggestions. First of all, the families of drug addicts can't be seen as homogeneous.

Reviewing the literature, it can be deduced that, in our terms, the work of Jay Haley on "crazies," young people when it refers to addicts, centers on families of type B or C. Haley himself underlines the difference between the two types when he refers to problems more or less serious, and when he speaks of one parent involved in the addiction, as opposed to two parents hyper-involved.

Quite similar descriptions are found in the work of Kaufman and Kaufman on the families of drug addicts. And it may be that Stanton and Todd, by choosing families in which the addict accepts long-term methadone treatment, end up dealing especially with type B families, (although it is clear that some of the cases the authors describe are type C).

In accord with our hypotheses about the typology, therapists who are system-oriented can expect some correspondence between the context in which they work and the kind of families they encounter to work with.

Secondly, the typology provides a good perspective about different ways, apparently confusing, that drug addicts are treated. For these differences, both in theory and practice, are so marked, that only two explanations are open: either the different therapies have specific application for certain kinds of drug addicts, or the addicts eventually select out the therapy which best suits them.

The data we have presented support the second of these explanations. From a systemic point of view, it might be that one should think about family therapy as one of several settings in which we need to work with drug addicts. An individual approach, for instance, is preferable with addicts of type A (traumatic), even if a paradigm aimed at the system is used. And it might be that a long-term therapeutic program in a community combined with family therapy is the better solution for addicts of type C (transitional). On the other hand, for addicts of type B (actual neuroses), the ideal might be family-therapy or a short-term program in a community combined with a self-help group for parents.

Finally, the clear and perhaps schematic distinction between families of type B and type C proves very useful when therapists who are systems-oriented have to choose between "structural" or "paradoxical" intervention; following Stanton's distinction, conversion or diversion therapies. Paradoxical prescriptions can be useful, but should be used when problems are quite serious and the family interactions show some level of psychotic communication. That is to say, in terms of our classification:

a) that "structural" family therapy can be used (and is fact is being used, formally and informally, in many settings whether or not they are specifically therapeutic) with families of type B; and

b) that the paradoxical and strategic approach should be adopted when the systems-oriented therapist encounters families of type C, and, less frequently, of type D.

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PREVENTIVE MEASURES

About Condoms, Spermicides, Gloves and Latex Barriers

CONDOMS: Latex (not natural) condoms are known to be effective in preventing other sexually transmitted diseases such as gonorrhea, syphilis, herpes, and chlamydia. Although no studies have been completed to prove that they will prevent the transmission of the AIDS virus, most researchers believe that latex condoms will offer at least some protection.

SPERMICIDES: Nonoxynol 9, the active ingredient in most spermicides (foams, creams, jellies), has been found to kill the AIDS virus in a laboratory dish, although we don't know for sure that it will kill the virus in the body. Many researchers believe, however, that it is a good idea to use a spermicide containing nonoxynol 9 as a backup in case the condom slips or breaks. Some lubricants also contain nonoxynol 9, but may not say so on the label. Check with a pharmacist to be sure. CAUTION: Some people are allergic to nonoxynol 9. Test the spermicide on the inside of your wrist before using it. If it stings or you get another reaction, try changing brands. A small amount of spermicide inside the tip of the condom increases sensitivity for the male partner.

DISPOSABLE LATEX GLOVES: If you have cuts or hangnails on your fingers or hands, physicians' disposable latex or rubber gloves will prevent contact with the AIDS virus during hand-genital or hand-anal contact. Gloves can be purchased at any dental or surgical supply house.

LATEX BARRIERS ("RUBBER DAMS"): Some sexologists have suggested that cunnilingus may be safe if done using a latex barrier between the tongue and vulva. This thin piece of latex comes in various sizes and is about the same thickness as a physician's disposable latex glove. Latex barriers come in rolls or sheets and can be purchased at dental and surgical supply houses (they even come with vanilla flavoring). At this time, no research has been done on whether or not they provide protection.

Disclaimer

There is no proof that condoms, spermicides, latex gloves, or latex barriers will prevent the transmission of the AIDS virus. Given the long incubation period, only time will tell if these measures are effective. However, most researchers believe that they offer at least some protection.

For more information call:
The SF AIDS Foundation Hotline at 415/863-AIDS
or COYOTE, 415/552-1849 or 415/381-3606

COMPILED BY THE WOMEN'S AIDS NETWORK, COYOTE, PROJECT AWARE
AND THE LESBIAN INSEMINATION PROJECT

CHAPTER 4

AIDS, ALCOHOL & HEALTH CARE

AIDS AMONG IV DRUG USERS: EPIDEMIOLOGY, NATURAL HISTORY AND THERAPEUTIC COMMUNITY EXPERIENCES

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Introduction

Acquired immunodeficiency syndrome (AIDS) is emerging as one of the greatest public health problems of the decade. The first United States cases were reported in the summer of 1981, and the number has risen to 13,216 through Sept. 20, 1985. Intravenous (IV) drug users form the second largest group of perons who have developed AIDS in the U.S. Three thousand three hundred ninety-three (26%) of the cases have occurred in IV drug users, including 1144 IV drug users who also have a history of male homosexual activity (1).

The number of cases of AIDS represents only a small fraction of the persons who have been exposed to Human T Cell Lymphotropic Virus type III/Lymphadenopathy Associated Virus (HTLV-III/LAV), the virus that is the primary cause of AIDS. Estimates of the number of persons who already have been exposed range up to 2 million. At present the number of exposed persons who will develop the full syndrome is unknown, with most estimates around ten percent.

Currently there are no effective treatments for AIDS, and the disease is almost uniformly fatal. Approximately three quarters of diagnosed cases die within two years of initial diagnosis (2). There is also no effective vaccine for the prevention of the syndrome. While there is intensive research in developing a vaccine, the rate of genetic change in the virus makes development of a vaccine much more difficult (3).

In this paper, we will summarize data on the epidemiology of AIDS among IV drug users, on the natural history of HTLV-III/LAV infection, and on the experiences of therapeutic communities with AIDS. A companion paper discusses the policy implications of AIDS for therapeutic communities.

Epidemiology

The development of antibody tests for exposure to HTLV-III/LAV has greatly improved our ability to conduct epidemiologic studies of AIDS among IV drug users for several reasons. Previously, epidemiologic research had to use actual cases of surveillance definition AIDS as a dependent variable. The long and variable time period between viral exposure and development of the disease (4) and the high ratio of exposed persons to AIDS cases at any single point in time both make numbers of exposed persons a much more powerful variable for analysis than numbers of AIDS cases.

It is clear that the sharing of works for injecting drugs is the primary method of transmitting HTLV-III/LAV virus among IV drug users (5,6). In terms of viral transmission, "needle sharing" should be defined to include the sharing of the syringes used for injection, and possibly even the "cookers" used for preparation of the drugs. Heroin and cocaine are by far the most commonly injected drugs among IV drug users who have been exposed to the HTLV-III/LAV virus, but the particular drug being injected does not appear to play an important part in the spread of the virus (7).

In the United States, the AIDS epidemic in IV drug users is centered in the New York City metropolitan area. Our 1984 studies of HTLV-III/LAV seropositivity among IV drug users in New York City showed approximately 60% of the IV drug users had been exposed to the virus. This did not vary significantly among subjects recruited from methadone maintenance, detoxification or therapeutic communities (8). Studies conducted by Weiss and colleagues (9) in New Jersey show a range from 50% seropositive in the northern part of the state, near New York City, to only 2% in the southern part of the state. Studies of seroprevalence in San Francisco and Chicago found approximately 10% postive in both cities (10). Clearly the AIDS epidemic among IV drug users is most advanced in the New York City area, but it has also started in other cities with large numbers of IV drug users. Prevention efforts are needed throughout the country, but particularly in areas like San Francisco and Chicago, where the great majority of IV drug users have not yet been exposed to the virus.

We have also conducted historical studies of the epidemic in New York City, using serum samples that were originally collected for other purposes. We have sera from IV drug users that go back to the middle 1960's. The first indication of HTLV-III/LAV antibody presence is in one of eleven samples from 1978. Seroprevalence then increases greatly--29% of 40 samples in 1979 were positive, 44% of samples from 1980, and 52% of samples from 1982 (11). The HTLV-III/LAV virus appears to have been introduced among IV drug users in the late 1970's in New York City and the seroprevalence rate has increased by about 5% per year since then.

Data on HTLV-III/LAV seroprevalence among IV drug users in countries of the world is somewhat limited, but does indicate that the virus is well established among IV drug users in continental Europe. There is are published reports showing 36% seropositivity among IV drug users in Zurich (12) and 34% among IV drug users in Germany (13), and preliminary data showing approximately 20% among IV drug users in Holland (14), 30% among IV drug users in Milan (15), and 20% among IV drug users in Stockholm (16). In contrast to the continent, a report from London showed only 1.5% serpositivity among IV drug users (17). At present, there is no comprehensive explanation for the variation in HTLV-III/LAV seropositivity rates among IV drug users in different parts of the world. Hypotheses are being tested to see if differences in needle sharing between male homosexual and heterosexual IV drug users, or in male homosexual prostitution among IV drug users, may account for the variation. Research is being conducted to test these. Regardless of the exact reasons for these geographical differences, it is clear that the AIDS problem among IV drug users must be considered a truly international one, and not confined to the United States.

In the United States, IV drug users form a link to two other groups at increased risk for AIDS-heterosexual partners and children. Of the 186 cases of AIDS among children reported through Sept. 20, 1985, 98 (53%) had an IV drug using parent. Of the 133 cases reported where heterosexual transmission appears to be the route of exposure, 97 (73%) involved transmission from an IV drug user. In the U.S., heterosexual transmission appears to be almost exclusively from male to female. Only 13 of the heterosexual transmission cases are male (18). Reasons for the great preponderance of females are currently under investigation.

Risk Reduction

There is a common stereotype that IV drug users are not at all concerned about health, and are not likely to change their behavior in order to avoid exposure to HTLV-III/LAV. Much of the stereotype appears to be based on observations of very unsanitary "shooting galleries" (19,20). Despite this stereotype, there is consistent evidence from a variety of sources to show that IV drug users in New York City have changed their behavior in order to reduce the chances of exposure to the AIDS virus.

We have conducted studies using interviews of IV drug users in treatment (21), not in treatment (22), and of persons selling needles for drug injection (23). All of these studies showed that IV drug users in New York City knew of AIDS, and the great majority (approximately 90%) knew that it was spread through sharing needles. Approximately 60% of the subjects reported efforts to reduce the chances of exposure to the AIDS virus, primarily through increased use of sterile needles. This self-reported increase in sterile needles was confirmed in our interviews of persons selling needles, who reported an increase in demand for sterile needles as a direct result of the AIDS epidemic. Limited availability of sterile needles was also noted as a major constraint on risk reduction in our studies of IV drug users not in treatment.

It is not yet possible to quantify precisely the amount of reduced needle sharing that has occurred among IV drug users in New York City. Drawing a truly random sample of IV drug users, and then monitoring their behavior over time, would be an enormously complex research undertaking. All of our present evidence, however, does indicate that efforts to reduce transmission of HTLV-III/LAV are occurring as a result of knowledge of AIDS. IV drug users should not be considered unresponsive to the threat of AIDS. (Some of the specific issues regarding possible ways to increase risk reduction among IV drug users not in treatment are discussed in the accompanying policy issues paper.)

Natural History

The course of HTLV-III/LAV infection after a diagnosis of AIDS has been well studied, but there is comparatively little knowledge of the early "natural history" of HTLV-III/LAV infection among IV drug users. Important aspects of the natural history yet to be determined include significant events in the early course of the infection, the different possible outcomes for IV drug users exposed to the HTLV-III/LAV virus and the distribution of exposed persons across the different outcomes.

We are currently following a group of over 300 IV drug users, approximately 60% of whom have been exposed to HTLV-III/LAV. This will permit us to monitor the early course of HTLV-III/LAV infection as well as to determine the various possible outcomes. The decline of T4 (helper) cells to an abnormally low level appears to be an important marker in the infection process. This event is associated with a variety of changes in immunologic status, including increases in serum immunoglobulins and serum beta-2 microglobulin, and increases in ARC symptoms (24). It may mark a point where serious impairment of the immune system begins, and after which treatment may need to include reconstitution of the immune system as well as halting HTLV-III/LAV viral replication.

Surveillance definition AIDS and AIDS-related complex (ARC) are the two best known outcomes of HTLV-III/LAV infection, but certainly not the only possible ones. Most IV drug users exposed to HTLV-III/LAV will probably not develop AIDS or any other significant health problems as a result. There is, however, increasing evidence of direct HTLV-III/LAV effects upon the central nervous system, leading to a syndrome that resembles Alzheimer's disease (25). There have also been epidemics of non-AIDS pneumonia and tuberculosis among IV drug users in New York City that coincide with the AIDS epidemic (26), and preliminary indications in our data of increased rates of endocarditis among IV drug users exposed to HTLV-III/LAV. It is important to determine if exposure to HTLV-III/LAV does increase susceptibility to these other serious illnesses that are not normally associated with AIDS. Given the large number of persons who have already been exposed to HTLV-III/LAV, we need knowledge of the full range of possible outcomes from exposure.

One of the most frequently asked questions regarding the natural history of HTLV-III/LAV infection is the likelihood of developing AIDS. The most common estimates center on ten per cent of those exposed developing surveillance definition AIDS. In our present study we have found 2.5% developing AIDS within the first year of follow-up, which is consistent with an overall estimate of ten per cent. In light of the other possible outcomes noted above, many of which are disabling or fatal in themselves, the percentage of persons who develop severe health problems as a result of HTLV-III/LAV exposure will very likely be much greater than ten per cent.

Co-Factors

Our follow-up of HTLV-III/LAV exposed IV drug users is also being used to examine possible co-factors that might influence the progression of HTLV-III/LAV infection. Given the absence of effective treatment and large numbers of persons who have already been exposed to the virus, identification of co-factors may have great potential for reducing the adverse consequences of viral exposure. If co-factors involve modifiable behavior, then it may be possible for many persons who have already been exposed to take actions that would reduce the chances of adverse outcomes.

The potential co-factors that we are examining include continued drug injection/repeated exposure to the virus, exposure through multiple routes, use of non-injected drugs (particularly alcohol and marijuana), stress, and other illnesses. Our preliminary findings indicate that multiple exposure to the virus may have deleterious effects, and recommendations to persons who have already been exposed should advise against activities that may lead to additional exposures.

Therapeutic Communities and AIDS

The most knowledgable individual at each of 15 therapeutic communities in different parts of the United States was interviewed by telephone in order to assess the prevalence, treatment and particular concerns about AIDS in therapeutic communities. Results of the interviews are briefly summarized below.

Five of the TCs reported having residents with AIDS in treatment. In an additional TC, there were clients who tested positive to the HTLV-III/LAV virus, but who were otherwise asymptomatic. All of the TCs with active cases made the existence of the cases known to residents, but only one community disclosed the client's identity. Five of the 15 TCs reported that residents had been diagnosed as having AIDS after leaving treatment.

Programs were also asked if clients who had already been diagnosed with AIDS or AIDS related illness had been accepted into treatment. Four programs had accepted individuals who were symptomatic, 1 program had refused admission to such an individual, and the other 10 had not yet been asked to admit anyone diagnosed with the disease. Of these 10, three said they would admit based on the individual's medical condition, three said they would refuse admission, and four stated they had no policy or established guidelines on which to base an admission decision.

The TCs were also asked what forms of AIDS education had been conducted at the programs. All but two of the programs had provided some form of AIDS education to staff and/or residents. Of these programs, most (8) involved both staff and residents in the educational effort (e.g., seminars, counseling, or literature distribution), while 4 involved only their staff.

From the phone interviews it became apparent that a minority of programs had not begun facing either the moral or the practical issues involved in AIDS among IV drug users, particularly regarding TC treatment for persons with AIDS related illness. For some of these programs, the interview process appeared to spur consideration of the issues. The majority of the programs had begun to address the issues, but lacked necessary information and had not resolved the potential value/philosophical conflicts.

Finally, the TCs were asked about what information and services they needed to deal with AIDS. The predominant issues and needs expressed by the 15 therapeutic communities included (1) the availability and dissemination of comprehensive and reliable information concerning the disease; (2) the delineation of a rational admissions policy based on facts; (3) the availability of resources for testing of individuals prior to admission into treatment; (4) the elucidation of issues specific to the treatment of the terminally ill, and (5) the establishment of a TC for the care of substance abusers with AIDS or related illnesses.

Summary

Over the last four years, AIDS has emerged as a major health problem for intravenous drug users, with great impact on persons involved in drug abuse treatment. AIDS is creating many new relationships between IV drug use and death. First, it is increasing the death rate among IV drug users. Second, the long latency period means that an individual may now successfully cease drug use, only to die a few years later. Formerly one could be essentially certain that the health risks from IV drug use could be immediately controlled simply by ceasing to inject. Third, heterosexual and in utero transmission of the virus place the spouses and newborn children of IV drug users at risk of a fatal disease even though they do not inject drugs themselves. Fourth, it is creating demands for types of services, centered around issues of death and dying, that were not previously required in drug abuse treatment. Finally, even though there is no evidence for casual contact or shared living arrangement transmission, AIDS does provoke fears of death among persons associating with IV drug users.

Specific policy questions for therapeutic communities related to the emergence of AIDS are discussed in an accompanying paper. Our review of the epidemiology and therapeutic community experiences with AIDS indicates that spread of the virus is generally well ahead of the development of strategies for coping with the difficult problems that AIDS presents for therapeutic communities. It is apparent that therapeutic communities need to consolidate efforts and resources for coping with the philosophical/value and practical issues related to the epidemic.

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AIDS AND THERAPEUTIC COMMUNITIES: POLICY IMPLICATIONS

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Introduction

The acquired immunodeficiency syndrome (AIDS) is adding new meanings to intravenous(IV) drug use, both for IV drug users and for persons who have never injected drugs. Because the disease is almost uniformly fatal among those who have been diagnosed with surveillance definition AIDS, it generates a level of fear that is much greater than that associated with other diseases common among IV drug users. This fear has led current IV drug users to increase their use of sterile needles in an attempt to avoid exposure to the AIDS virus (1).

Treatment programs in which a client has developed AIDS have undergone great stress over possible transmission of the virus among clients and from clients to staff, as well as over the impending death of program members.

In addition to the practical problems associated with infection control, AIDS raises new policy questions for therapeutic communities (TCs). In this paper we will discuss three policy issues that have arisen as a result of the AIDS epidemic: using (or not using) the antibody tests that indicate exposure to HTLV-III/LAV (the virus that causes AIDS); devising strategies for preventing AIDS among IV drug users; and providing residential treatment to persons who have AIDS. We will also comment briefly on the need for forming working alliances with the other groups most directly affected by the epidemic.

In discussing these policy issues, we will draw both upon our experiences in conducting research on AIDS in IV drug users and upon our observations of the AIDS epidemic in the New York City metropolitan area (which to date accounts for approximately 80% of the cases of AIDS among IV drug users in the U.S (2)). We do not, however, want to create the impression that there is a single set of "right" answers to these policy questions. In many instances the "best" answers may vary according to the individual, the specific program or the specific geographic locality. Furthermore, the processes by which new policies are adopted may be as important as the content of specific policies. Hopefully those affected will participate in, or at least be represented in, the policy deliberations.

Before discussing these three policy issues, several comments on the transmission of HTLV-III/LAV are also appropriate. As noted in the accompanying paper that reviews the epidemiology of HTLV-III/LAV, heterosexual transmission (particularly from male to female) and in utero transmission of the virus both occur. In the United States, IV drug users are the primary sources for these types of transmission (3). While all evidence indicates that HTLV-III/LAV is not spread through any form of casual contact transmission, there is great public concern that the virus might be transmitted this way (4,5). Policy issues regarding AIDS among IV drug users must not only consider IV drug users, their sexual partners and children as potential victims of AIDS, but also public fears of casual contact transmission.

One of the most important aspects of AIDS is the long time period betwen exposure to HTLV-III/LAV and development of the disease. This "latency period" is presently estimated to be about five years (6). Many of the most difficult policy decisions that face TCs are linked to this long latency period. Death has always been a frequent consequence of injecting illicit drugs, but the linkage was close in time. If one had not died from drug use, then stopping would almost certainly guarantee protection against any future drug related death. AIDS breaks this linkage between current behavior and consequences. IV drug users, and those who treat them, must now worry that even drug users who successfully abstain from further drug use may die or transmit a fatal disease to their spouses or unborn children as a consequence of their previous drug use. This potential futility of successful drug abuse treatment is an underlying thread in the first three of the policy issues we will discuss.

HTLV-III/LAV Antibody Testing

Commercial tests for antibody to HTLV-III/LAV are now available, and there is great debate as to the proper use(s) of the test. These tests measure exposure to HTLV-III/LAV, but they do not predict whether or not an individual will ever develop any disease as a result of the exposure. HTLV-III/LAV is generally not cleared from the body, however, so that an exposed person must be considered as probably capable of transmitting the virus at any time after exposure.

There is general agreement that the tests should be used for research and for screening blood donations, and that persons who wish to know their antibody status have a legal/moral right to this knowledge. Areas of disagreement include the extent of counseling that should be provided along with test results; informing sexual partners of antibody positive persons; and use of the tests for employment, educational, or health insurance eligibility decisions.

Since there is as yet no effective treatment for AIDS, knowledge that one has been exposed to HTLV-III/LAV can create great psychological stress. Responses to this stress can include suicidal behavior and increases in transmission related behavior (to take psychological revenge upon those who exposed the individual). Therapeutic communities provide ongoing counseling services to IV drug users at risk for HTLV-III/LAV exposure, and are resources with expert knowledge in counseling drug abusers. The extent to which therapeutic communities should devote counseling resources to IV drug users who wish to learn their antibody status is a difficult question. The answer will likely vary at least in part upon the demand for testing among IV drug users and the availability of other counseling resources.

A particularly complex aspect of counseling regarding the antibody test arises with respect to family planning. The great majority of IV drug users are of child bearing age, and many are actively contemplating having children (7). There is something of a consensus that an HTLV-III/LAV antibody positive woman should postpone pregnancy until more is learned about the likelihood of transmission to the fetus.

A second complex issue in antibody test counseling for a seropositive individual concerns informing others who may have been or may be currently at risk of HTLV-III/LAV exposure from the seropositive individual. This is not a great problem regarding persons who may have shared needles with the target individual, since they presumably already know they are at some level of increased risk for HTLV-III/LAV exposure, and therefore it would be quite difficult to locate many of these individuals. Current sexual partners of an antibody positive individual would be relatively easy to locate, may well not have been already exposed, may be able to take effective measures to guard against exposure (without necessarily ceasing the sexual relationship), and may also wish to know for family planning purposes. Such sexual partners, however, may not know that the specific individual has a history of drug injection. Informing others who may be currently at risk for exposure presents a potentially extreme conflict between the rights of the individual being tested and the person potentially being exposed. Our present recommendation in this area is that the issue of who would be informed should be addressed as part of an individual's decision to be tested.

The question of antibody testing in contemplation of having children also applies when the relationship between the potential father and potential mother is still in an early stage. Romantic relationships frequently develop among residents of TCs, with the intention of marriage after completion of treatment. In this situation, there is the possibility that a resident may want to know the antibody status of a potential spouse. (There have been suggestions that HTLV-III/LAV antibody testing be made manditory as part of obtaining marriage licenses, though it does not look like this will occur soon.) There are no easy solutions to the problems presented when a resident wants to know the antibody status of a potential spouse and that person does not want to be tested, or if testing is done and positive results are found.

A final problem concerning HTLV-III/LAV antibody testing of TC residents involves maintaining the confidentiality of the results. Maintaining confidentiality is legally and ethically fundamental to any successful testing. Even if all standard methods for maintaining confidentiality were used in a TC, however, there would be problems. The emotional impact of an antibody positive result is likely to be sufficiently great enough to be detected in the normal close observation and group encounter sessions within TCs.

Preventing AIDS among IV Drug Users

Strategies for reducing HTLV-III/LAV transmission among IV drug users also present difficult policy choices. As noted in the accompanying paper that discusses the epidemiology of HTLV-III/LAV, prevention of viral exposure among IV drug users would reduce exposure of heterosexual partners and children. Prevention strategies must therefore include consideration of the persons to whom IV drug users may transmit the virus as well as IV drug users themselves.

HTLV-III/LAV is not transmitted through drug injecting in itself, but rather through the sharing of works to inject drugs (8,9). (Transmission may occur sharing of not just the needle, but also the syringe, and possibly the "cooker" used to prepare the drugs for injection.) Persons who are currently injecting drugs may thus greatly reduce their chances of exposure to HTLV-III/LAV by changing from needle sharing to using their own needles and works. They may also reduce the chances of HTLV-III/LAV transmission by cleaning their works in solutions of 40% alcohol or 10% household bleach, both of which will kill HTLV-III/LAV.

There is consistent evidence from New York City that IV drug users will use knowledge about HTLV-III/LAV transmission to reduce needle sharing and increase their use of sterile needles (10). Thus informing drug users about HTLV-III/LAV transmission through needle sharing may lead to important behavior changes to reduce transmission. (Whether informing IV drug users of specific ways to clean needles that kill HTLV-III/LAV leads to adopting these practices has not yet been studied, but must be considered as a possibility.)

Providing drug users with information on how they may continue to inject drugs while greatly reducing the chances of HTLV-III/LAV transmission will be seen by some as a necessary public health prevention measure. Others will see it as counterproductive encouragement of drug use. Information about transmission through needle sharing has been distributed by drug abuse treatment and public health authorities in New York City and San Francisco since 1984. Distribution of a pamphlet containing the same information was halted in Los Angeles because county supervisors believed that it was encouraging drug use (11).

The question of preventing HTLV-III/LAV transmission versus encouraging drug use is relevant not only to distributing information about needle sharing, but also to questions of the legal availability of sterile needles for IV drug users. At present, prescriptions are required for the purchase of hyperdermic needles in only 11 states and the District of Columbia (12). The 11 states include some with high concentrations of IV drug users, e.g. New York, New Jersey, California, Illinois. Other states with high concentrations of IV drug users, e.g., Michigan, Louisiana, do not require prescriptions. Public health authorities in New York are currently considering changing the prescription requirement as a method for preventing HTLV-III/LAV transmission. Much of the discussion concerns the extent to which removing the prescription requirement might encourage drug use, particularly whether it might encourage persons to start injecting who otherwise would not.

As persons with expertise in what does and does not encourage people to inject drugs, TC staff must expect to participate in public health considerations of what information about AIDS should be disseminated to IV drug users and what are the appropiate legal restrictions on the availability of sterile needles during the AIDS epidemic. TCs will also have their own specific prevention situation with regard to persons splitting from treatment. A large percentage of persons entering TCs do split, and staff are often aware of who is about to split. Splittees must be considered at high risk for injecting drugs, and thus for exposure to HTLV-III/LAV. What, if anything, should staff tell a resident about to split about HTLV-III/LAV transmission? How does one balance needs to retain residents until they complete treatment with reducing exposure to HTLV-III/LAV among residents who do split? We do not want to advocate any specific positions on these policy questions, but do wish to make three general comments relevant to AIDS prevention among IV drug users.

The first is that the actual effects of actions that may reduce HTLV-III/LAV transmission and/or may "encourage" drug use are subject to empirical study. There are many myths and stereotypes regarding what does and does not motivate people to begin or change drug use. Conclusions from well conducted studies prior to the AIDS epidemic may or may not apply to the changed situation. Important mistakes could be made with respect to prevention efforts unless appropriate data are utilized in decision-making.

Second, debates over proper prevention strategy are not likely to lead to constructive action unless there is a willingness to recognize the validity of the emotional experiences of persons working with different aspects of the problem. Persons working in law enforcement, drug abuse treatment or prevention programs are likely to have had many personal experiences that convince them of the great need to do everything possible to discourage drug use. Similarly, persons working with AIDS patients will have had intense emotional experiences that convince them of the need to do all possible to prevent transmission of HTLV-III/LAV. Unless there is an awareness and respect for these different emotional experiences, it is not likely that concerned groups will be able to arrive at prevention programs that are acceptable throughout the community.

A third comment concerns the need for multiple approaches to AIDS prevention efforts. Neither IV drug users, nor those at high risk for becoming IV drug users, are homogeneous groups. Different prevention activities will undoubtedly be needed for the different subgroups. The range of prevention activities could include disseminating information about AIDS, the means of HTLV-III/LAV transmission and how to clean needles; increasing the availability of treatment for those who wish to enter; increasing the legal availability of sterile needles for those who do not want to enter treatment; providing antibody testing and counseling for individuals who wish to learn their antibody status; and working with youth at high risk of starting to inject to prevent them from becoming IV drug users.

Residential Treatment for IV Drugs Users with AIDS

A third policy issue concerns housing of current and former TC residents who have developed AIDS. Almost all IV drug using AIDS patients will require an initial hospitalization during the period in which a diagnosis of AIDS is being made. With the increasing ability to treat the clinical manifestations of AIDS, the majority of these patients will recover sufficiently to a point where they no longer need hospitalization. Maintaining such patients in the hospital when this level of medical care is not required is very expensive, and is particularly difficult to justify given the great demands on medical resources that have been created by the AIDS epidemic.

If the AIDS patient had been a resident in a TC, the question of taking the patient back into the TC poses difficult problems. Some of these problems are practical, in terms of providing the level of supportive care that such a patient may need and of maintaining proper infection control. The most difficult problems, however, are in the conflict between handling issues of death and dying for some while also trying to instill hope for a drug free life in others.

The sense of family created within TCs leads staff and residents to want to take back a resident with AIDS, particularly if that patient does not have another place to live. Not to take back such a patient seems a betrayal of the commitments to helping each other that are made as part of life in a TC.

Providing housing within a TC to an IV drug user with diagnosed AIDS, while in keeping with the fundamental spirit of mutual assistance, also poses challenges to the treatment philosophy of TCs. An AIDS patient who does not require hospitalization may not be able to participate fully in the regular activities of TC life. A special TC treatment program, determined primarily by AIDS illness factors, would have to be created for such a resident. This program would be contrary to many of the rules that relate rewards and privileges to behavior within the program, and would have to include special counseling around issues of death and dying.

In addition to the need to create a special program for an AIDS patient within a TC, the presence of a resident with AIDS would also be seen as a contradiction to the sense of hope needed to overcome drug addiction. The presence of an AIDS patient within the program might serve as a constant reminder that successful efforts to achieve a drug free lifestyle may nonetheless be followed by a fatal drug-related illness.

The anti-motivational effect of an AIDS patient in the program may be seen directly through a negative fatalism--"I may get AIDS anyway, so why not go back to doing drugs"--or indirectly. One indirect expression of fear of AIDS is in excessive concerns with casual contact transmission from the AIDS patient. Concerns about transmission from sharing living arrangements are often incorrect on two grounds. All current epidemiologic evidence shows no viral transmission from sharing living arrangements with AIDS patients. The precautions that should be taken to limit hepatitis B transmission are effective in preventing AIDS transmission. In addition, it is the asymptomatic carriers, persons with the virus but without any evidence of disease, who are probably most able to transmit the virus to others. The AIDS patient, identified as having the disease, is a convenient target for displaced fears of AIDS. A progam that does provide residential treatment to an AIDS patient will not only have to provide accurate information on transmission to staff and other residents, but will also have to cope with the fears of all ex-IV drug users that they may develop the disease.

As if the problem of whether or not to take a resident who develops AIDS back into a TC were not sufficiently complicated, there are variations that guarantee additional difficulties. One variation is an IV drug user with AIDS who is not a former resident but does want TC treatment. Assuming that the person's health status would permit some level of participation, and that proper medical support could be handled within the program, should he or she be admitted? The program does not have the same sense of responsibility associated with a former resident, but should TCs take a position that such a person must either enter other forms of drug abuse treatment or no treatment at all?

Policy decisions regarding accepting AIDS patients within TCs must also address patients with AIDS related complex (ARC). ARC can be seen as a milder version of AIDS that may or may not lead to full surveillance definition disease. The problems of special treatment needs, dilemmas for treatment philosophy, and threats to motivation are applicable to ARC patients as well as to AIDS patients. Because there will probably be more ARC patients than AIDS patients who do not require hospitalization, it may even be best to frame the policy decisions in terms of the conditions under which TCs should provide treatment for ARC patients. Decisions regarding AIDS patients could then be logical extensions of policies with regard to the ARC patients.

As a final comment on the policy issues regarding housing/residential treatment of drug users with AIDS or ARC, we should note that these should not be addressed by TCs in isolation. The problem requires coordination with the hospitals that provide the medical care needed by AIDS patients, other drug abuse treatment programs, and community social service groups that attempt to provide a wide variety of needed support services to persons with AIDS related diseases.

Working Alliances

The above comment on the need for coordination with others in the community who are providing services to persons with AIDS related disease leads to the final question that we wish to raise in this paper. This is not a policy issue in the sense of the three previously discussed, but may involve similar processes of value exploration and conflict resolution. Homosexual men are the largest group to have contracted AIDS. They have also taken the leadership role to press for resources for research and treatment for AIDS and have organized a variety of community support services for persons with AIDS or ARC. As the two largest groups to develop AIDS (in the US and in Western Europe) gay men and IV drug users will have strong common interests in a variety of AIDS related issues. These include minimizing discrimination against persons with AIDS and/or exposed to HTLV-III/LAV, as well as research, treatment and support services.

Gay men and drug abuse treatment providers do not come to these new common interests from a background of mutual understanding. Both groups have tended to hold disrespectful stereotypes of the other. The IV drug user subculture has tended to deny homosexual feelings among men, and this has often been carried over into programs that utilize ex-addicts as counselors. The gay subculture has tended to deny the abuse potential of drugs. Ethnic and social class differences between these two groups provide additional bases for misunderstandings. For these two groups to learn to work together effectively will require not only the usual skills of cooperation and compromising, but also personal examinations of fears and prejudices regarding the other group.

Summary

AIDS is not simply another adverse consequence of injecting drugs. The characteristics of the disease, including the high fatality rate, the long latency period, and sexual and in utero transmission, form an unprecedented and deadly combination. Barring an unexpected breakthrough in either treatment or vaccine research, all treatment programs that work with IV drug users must adapt to a new, and realistic, fear of death.

Specific problems that AIDS raises for TCs include using (or not using) the antibody tests, devising AIDS prevention strategies, providing residential treatment to drug users with AIDS, and forming working alliances with others greatly affected by the epidemic. The first three of these require TCs to confront directly the potential demoralization caused by a drug-abuse-caused death that cannot be prevented by stopping current drug use. The fourth will require new cooperative skills and a willingness to examine and revise possible personal prejudices. Some TCs have had to work through these policy dilemmas on a crisis basis. Others have the opportunity for some contemplation and planning prior to a crisis.

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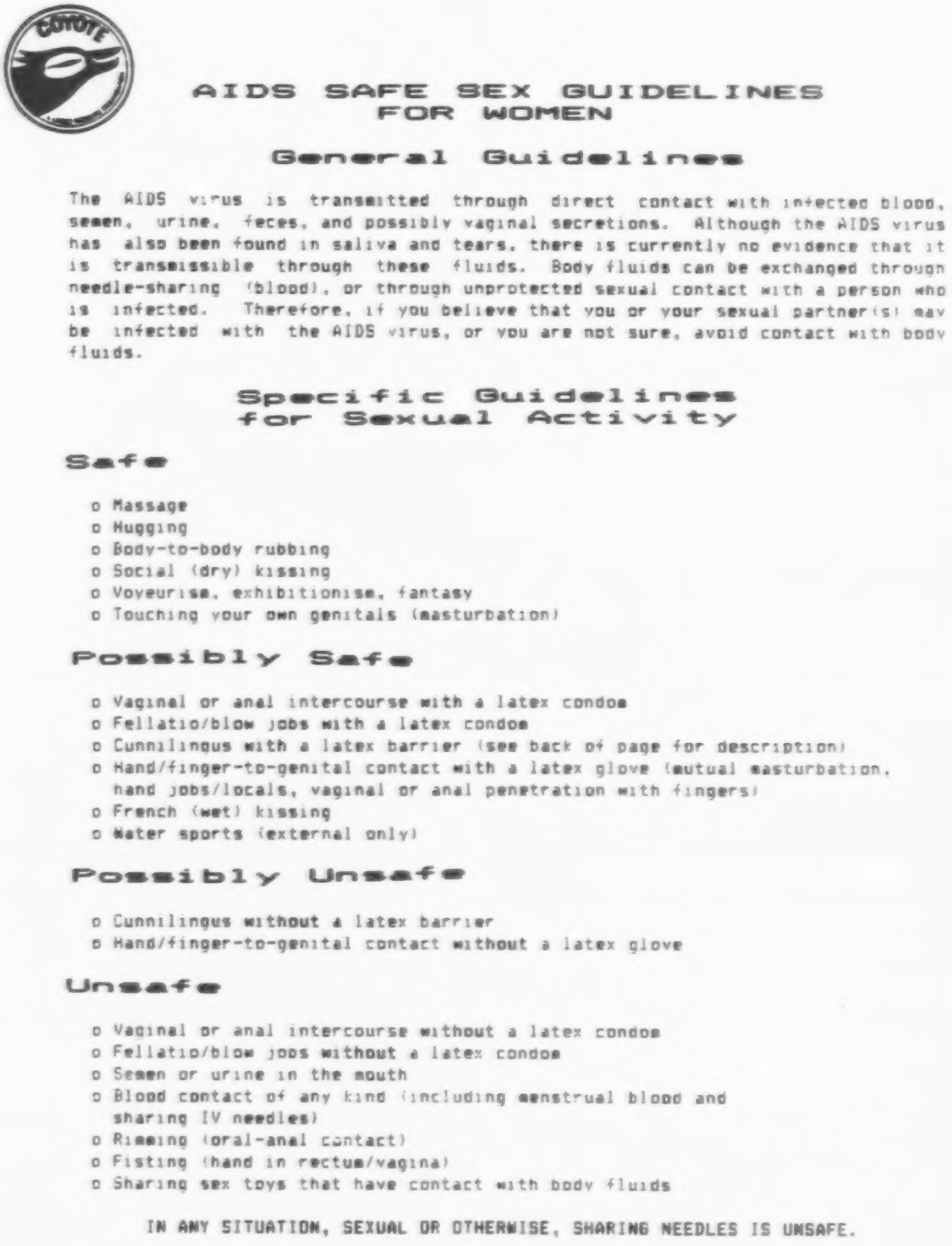

AIDS SAFE SEX GUIDELINES FOR WOMEN

General Guidelines

The AIDS virus is transmitted through direct contact with infected blood, semen, urine, feces, and possibly vaginal secretions. Although the AIDS virus has also been found in saliva and tears, there is currently no evidence that it is transmissible through these fluids. Body fluids can be exchanged through needle-sharing (blood), or through unprotected sexual contact with a person who is infected. Therefore, if you believe that you or your sexual partner(s) may be infected with the AIDS virus, or you are not sure, avoid contact with body fluids.

Specific Guidelines for Sexual Activity

Safe

- o Massage
- o Hugging
- o Body-to-body rubbing
- o Social (dry) kissing
- o Voyeurism, exhibitionism, fantasy
- o Touching your own genitals (masturbation)

Possibly Safe

- o Vaginal or anal intercourse with a latex condom
- o Fellatio/blow jobs with a latex condom
- o Cunnilingus with a latex barrier (see back of page for description)
- o Hand/finger-to-genital contact with a latex glove (mutual masturbation, hand jobs/locals, vaginal or anal penetration with fingers)
- o French (wet) kissing
- o Water sports (external only)

Possibly Unsafe

- o Cunnilingus without a latex barrier
- o Hand/finger-to-genital contact without a latex glove

Unsafe

- o Vaginal or anal intercourse without a latex condom
- o Fellatio/blow jobs without a latex condom
- o Semen or urine in the mouth
- o Blood contact of any kind (including menstrual blood and sharing IV needles)
- o Rimming (oral-anal contact)
- o Fisting (hand in rectum/vagina)
- o Sharing sex toys that have contact with body fluids

IN ANY SITUATION, SEXUAL OR OTHERWISE, SHARING NEEDLES IS UNSAFE.

CAN RECOVERING ADDICTS DRINK?

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I have this opportunity as a friend of the therapeutic community movement to speak today on one of the more controversial issues that relates to the therapeutic community movement, namely, can the ex-addict drink? The therapeutic community had its origins in working with the heroin addict at a time when heroin addiction was seen as something separate from alcoholism. It is interesting, however, that the first therapeutic community, Synanon, evolved from an initial experience with Alcoholics Anonymous, which has a separate history and tradition. It was the perception that the heroin addict and the alcoholic were very different, in terms of behavior, in terms of response to drugs. You saw in these separate systems different views, philosophies, even a different language.

In the 80's these separations and differences are becoming progressively more dysfunctional. They start from the street and go right on up to the treatment staff and the leaders of the therapeutic community movement. I want to emphasize that the division does start on the street. When I started in the addiction field 20 years ago at San Francisco General, the heroin addict would point his finger at the alcoholic and call him a "juice freak" and the alcoholic would point a shaky finger at the heroin addict and call him a criminal and a pervert. Alcoholics and addicts don't like each other right from the beginning. It moves up through treatment staff to leadership, with ç the perception that these are very, very separate. In fact, as these different movements have evolved and clearly done an outstanding job dealing with individuals who have addictive disease, there has been a parallel development in the field of addictionology, which is based on the study and treatment of addictive disease. There has also developed a whole philosophy as it relates to inpatient chemical dependency treatment, and there is also a different epidemiology, including a different epidemiology of people who are coming in to a therapeutic community. The vast majority of young people in fact, are polydrug abusers.

The idea that people are drug specific, particularly that young people are drug specific, and will only use heroin, or will only use alcohol, or will just use methamphetamine or cocaine, is becoming a real rarity. The vast majority of young people who are in chemical dependency treatment programs are polydrug abusers. It's becoming clear from the research that if you have an addiction at one time you have a higher possibility of developing addiction of another type. The family evidence is that if you have a family history of alcoholism or other drug dependence, there is a substantially higher probability that the children will develop alcoholism or some form of drug dependence. This is becoming a more important issue because as the therapeutic community movement matures, many people are having children, the children are growing up, and the attitude that all you have to do is stay clean from one drug, or stay away from one drug, is becoming progressively more dysfunctional. A chemical free philosophy is evolving as the best and most effective way to recover from addictive disease of any type.

What I hope to do in the time I have is to briefly deal with the evidence that relates to the disease concept of addiction and then apply that to issues as I have seen them in the therapeutic community movement. Clearly the issue of alcohol in the therapeutic community movement is one of the more controversial ones.

It starts at the streets. We have people that are graduates of therapeutic communities come into Haight Ashbury Clinic and say, "I'm not using dope, heroin, so I don't have a drug problem any more." They're drinking a fifth of whiskey, a couple bottles of wine, their liver's enlarged, they're having drunk driving arrests. In fact, what has happened is that they've switched from the toxicity of one drug, heroin, which is highly criminalized -- you stick a needle in your arm, you have to steal a hundred dollars a day, that's a drug -- to another drug that's legal, and that's manifesting a very different toxicity.

We define recovery as living responsible and productive lives without the use of psychoactive drugs. Drug switching is not recovery. Changing from the toxicity of heroin and the dysfunction associated with heroin to the toxicity of alcohol and the dysfunction associated with alcohol is not progress. That is not recovery. Society may like it more, it tends to underreact to alcohol, even though alcohol in the United States is the third largest killer behind heart disease and cancer and produces more damage, in terms of health consequences, than all of the other drugs combined. But in terms of the health and welfare of that individual, switching from an illegal to a legal drug of abuse is not progress, but rather a way of moving from an illegal drug to a legal drug. In that context, you will also see situations that are quite controversial in terms of the people that are within the therapeutic community itself. I know this is an issue that many of you are debating at this time. This was reflected in the January-March 1984 issue of Journal of Psychoactive Drugs that was devoted to therapeutic communities. Many of the leaders of the T.C. movement published in this issue.

The introduction was by Robert Frye and stressed alcohol as an internal issue reflecting attitudes of a portion of the TC movement as it was related in the literature. He cites a statement by Herbert Freudenberger which represents the prevailing view of alcohol use in the mid 1970's:

> "Alcohol is an internal issue, re-entry should be viewed as the testing time, a time in which the resident, as well as the program, can evaluate what it has accomplished together. It is during this period the resident should be allowed to drink alcohol, possibly smoke pot, to test themselves on how successfully they can deal with these potential addiction problems. It was thought that the TC concept and philosophy were not sufficient to understand and deal with alcohol problems, and it was thought that the large peer pressure was not effective in controlling drinking behavior. In a few TCs, the question of whether alcohol or pot were permissible was decided by insisting on abstinence. Some gave drinking privileges to senior residents and some permitted controlled drinking in the re-entry stage."

First of all, I want to deal with this attitude. The Haight-Ashbury Free Clinic started as a street clinic. In the early 70s we were offered an alcohol grant, and our staff said, " No, we understand junkies, we are comfortable with junkies, but we don't understand these alcoholics." So we rejected the grant. You see that in the therapeutic community reflected by this literature. They were familiar with heroin addicts. "We understand heroin addicts, but we don't understand alcoholics." To begin with, in the field of addictionology, we've learned that the basic principles of treatment apply to all forms of addictive disease. In fact, the TC movement can be one of the most valuable in dealing with the disease of alcoholism, particularly as part of a poly drug abuse problem, if they would have common end points, if they would use their therapeutic modality to focus on abstinence and recovery rather than drug switching. In addition, in the Freudenberger quote it implies that the reason a person has a drug problem is purely environmental. He had the wrong neighborhood, the wrong house, the wrong environment, he had bad grades, he had character problems. That's how he became an addict.

As we understand addictive disease, more and more we're becoming aware that it is the broad formula of "Addictive disease = genetics + environment." There are environmental factors. But we're also becoming aware of the susceptible host, who manifests addictive disease as a consequence of an altered response to the drug. If you have higher susceptibility in the case of one drug, like an opiate, you will have higher susceptibility to the abuse of other psychoactive drugs, including cocaine and alcohol. These two are the ones that I'm finding TC s having the hardest time dealing with, particularly alcohol.

One of the things that's implied is that if you stay in the therapeutic community movement you mature, you correct character defects, and you can go out and drink, because that's the reward of a good life. Responsible people drink alcohol. In fact, I think that's playing Russian roulette with the individual's recovery. What I have seen, personally, are people who have gone into therapeutic communities, have perceived that drinking privileges are a reward for moving up the hierarchy. When they graduate they don't use opiates, but what I've seen are drunk driving arrests and the medical problems associated with alcohol abuse. I've seen them have all the signs and symptoms of alcoholism, including job and family disruption. When I see them, we see real tragedy. With one very prominent graduate of the TC, I testified on his behalf in court because he killed somebody in a drunk driving wreck and his son was drunk in the back seat. He wasn't using heroin, he wasn't sticking a needle in his arm. He wasn't stealing, he wasn't in jail. But his perception that he could drink socially, he could learn to drink in controlled circumstances, totally went out the window when he graduated, and he transmitted this message to his son. Research indicate that the sons of alcoholic fathers have a much higher probability of developing alcoholism or any addictive disease. The evidence is clearly in the direction that once you have addictive disease, it is very high risk to involve yourself with other psychoactive drugs, and in fact the most effective treatment on a long-term basis in a chemical-free philosophy. And, in that context, I think that what happens in some of the therapeutic communities is a form of a controlled drinking experiment.

There was a study done by the Sobels in which they studied the chances of success of converting alcoholics to controlled drinkers. In that circumstance, what happened was they took an alcoholic individual at the VA Hospital who had had a positive tissue dependence on alcohol, and did all sorts of things to teach them to return to the controlled use of alcohol. They claimed is was a great success and published it. I was skeptical at the time because I know that alcoholics spend most of their lives trying to control their drug use as do other addicts. It didn't seem to me that in the VA Hospital they did anything different than the alcoholic had already tried themselves. But they published this, that controlled drinking works for the alcoholic. In the followup study, half of the people had died from alcoholism, and the other half were abstinent. They were able to control the use while everybody was watching, in that tight, structured environment. But when they graduated and went on their own, alcoholism escalated dramatically, the disease of alcoholism manifested itself, and in fact the controlled drinking experiment was a failure. In a parallel fashion, control in a TC does not easily translate to control in the community.

As the therapeutic community movement has evolved, people graduate. You see them drink in the TC, and they look like they can control their alcohol use. But when they get out on their own, that compulsion, lack of control, continued use despite adverse consequences (which is a hallmark of the addictive process) manifests itself. Just because you see somebody in a tightly structured, highly observed situation temporarily control the use of alcohol does not mean on a long term basis that they will not cross the line back into a very serious alcohol relapse.

In addition, there's a growing body of evidence that if you violate a chemical-free philosophy, in this case with alcohol, it increases your relapse factor of primary drug of abuse. The current research in the brain chemistry of addictive disease indicates that with the alcoholic, an abnormal metabolite of acedaldehyde/isoquinolines interact with the opiate receptors so that with the alcoholic, alcohol may be even acting as an opiate in the brain. That's one of the reasons that individuals that have the disease of alcoholism will manifest an altered response.

In addition, there is some evidence that suggests that the abuse of alcohol can trigger drug hunger and if the drug hunger is conditioned to opiates or cocaine, they will relapse back to their ç primary drug of abuse. We see this all the time in our cocaine recovery groups. "My problem is cocaine, that's what's causing me all the difficulty." They stop using cocaine but when they violate a chemical free philosophy with alcohol, it triggers drug hunger, relapse is set up, and the next thing we know they're in the middle of a cocaine relapse. It is very clear that if an individual abuses alcohol and violates chemical free philosophy, it increases their chances of relapse back to their primary drug of abuse, either opiates or cocaine. I think this message should be given very, very clearly to individuals in the therapeutic community movement.

Now, I would also like to deal with some of the areas of resistance and controversy. Why is it perceived in spite of the growing body of medical evidence to the contrary, that addiction is purely environmental and people who stop being opiate addicts can be controlled drinkers? Why is their such hostility toward people who present the disease concept? I know, for example, when I present the disease concept and cross addiction, very often what I will get is a very negative response. I think part of it is a misunderstanding of the disease concept. The disease concept goes on the assumption that addiction is a pathological process with characteristic signs and symptoms, with a predictable prognosis without treatment. It is perceived in the field of addictionology as the best and most effective treatment for addictive disease are abstinence, recovery-minded treatment strategies that revolve around the group process. Well, that happens in TCs. There should be no inherent opposition to this. Part of it is because, at least the critics in mind, when you say to these doctors, we've accepted the disease concept within the therapeutic community movement, the next thing that's going to happen is that the doctors are going to take over the therapeutic community. Not true! If you define a disease, it in no way says that physicians are the ones to treat that disease. In fact, in my experience, physicians are some of the least successful individuals in treatment addictive disease. Accepting the disease concept in no way suggests that the medical profession, with all of its ignorance, will take over. On the other hand, if you accept that it's a disease, and you do have a physician that is recovery-sensitive and understands the addictive process, it can be a very valuable part of a health care team necessary to deal with addiction.

Beyond the attitudinal issues is an opposition to the disease concept which I think is a misunderstanding of the disease concept, I want to share with you some other issues that have been raised by Frye as regards TCs in opposition to enforcing alcohol abstinence. Despite the fact that the literature indicates that over 40% of therapeutic community newcomers have signs of alcoholism, and in fact may have had serious problems with alcohol prior to entering this therapeutic community, Frye describes the reasons for opposition within the TC movement to an enforced alcohol ban for ex-addicts, graduates, and staff as the following:

1. The realization that most graduates will at some point in time attempt social drinking and a drinking ban would promote secret alcohol consumption and alcoholism.

2. The total alcohol abstinence enforcement policy would prevent open discussion and intervention within the graduate and/or ex-addict staff member who attempts consumption and experiences problems.

3. Relating alcohol consumption to serious illicit drug consumption confuses those graduates who have not experienced problems with alcohol consumption and effectively causes banishment for the alcohol-consuming graduate and prevents possible use of the TC as graduate support and aftercare.

4. A policy of total alcohol as well as other drug abstinence in the graduate promotes a sense of guilt and the drug use of alcohol, leading to possible feelings of failure, low self esteem, low self image, thus facilitating progress from licit to illicit substances and involving a readdiction to the original drug of choice.

5. The policy of alcohol abstinence for ex-addict staff and not other TC staff, including professional staff, is discriminatory and forever locks the ex-addict into the former addict role and paraprofessionalism.

6. Finally, abstinence mandated by administrative fiat can only be temporary. Long term abstinence can only be promoted by consolidating permanent value, life style changes.

Well, again, as you can tell by these TC positions, they go on the assumption that if one advocates a chemical free philosophy, that's a moral position. It's as if I'm trying to tell you, like Carrie Nation, not to drink. We don't present it that way at all. We present alcoholism as a progressive and potentially fatal illness, based on a great deal of education within the treatment program itself.

Now, if the leaders of the TC believe that the reward of progress up the TC ladder is the right to use alcohol, then they're clearly not going to convey an abstinence message to the graduates. One of the things we must deal with, here in the TC conference, is the fact that major and historic leaders of the therapeutic community movement have fallen to the disease of alcoholism. It's not something that we want to publicize a great deal, but it's something that we're all aware of. Now, as you move up the TC hierarchy, if you believe the reward of progress up that TC ladder is the right to drink, then you're going to convey a very wishy-washy, ambivalent, fuzzy message to the TC graduates.

A more comprehensive and contemporary program that relates to alcohol in the TC movement can't just discourage it at the graduate level. It also has to come from the leadership of the therapeutic community movement. And if the leadership of the therapeutic community movement want to hold onto alcohol, you're going to have this inconsistency throughout the program. Again, you must deal with the reality that there have been a number of major and historic figures in the therapeutic community movement that are now at the present time active alcoholics. Some, of course, haven't died of the disease of alcoholism, they haven't died with a needle back in their arm, they haven't died of an overdose or opiate addiction, but they have died of the consequences of addictive disease, or suffered serious dysfunction as a consequence of their addictive disease, in this case alcohol.

I think it is also very important to think about future generations. What we're seeing more and more of in the field of addictionology is, "My father is an alcoholic, I thought I might have problems with alcohol, nobody ever told me about cocaine, I'm a cocaine addict." Or, "My parents had opiate addiction, I was born into it, I thought I might have problems with illegal drugs, I got involved with alcohol, now I'm an alcoholic."

It is considered that although environmental factors are a major force in drug of choice, psychosocial development, type of addiction, there is also the factor of the susceptible host. Although most of the research has been done with alcohol, it is clear that if you have a family history of alcoholism or other drug dependence, there is substantially higher probability that the children will have alcohol or other drug addiction problems. It has to be dealt with as a family issue. It is the concern of all of us that have recovery in our ç families. I've already mentioned some of the evidence that deals with altered response to alcohol early exposure, in terms of some of the biochemical evidence. There are also three studies that have been done in which children that are identical twins born into alcoholic families, were raised separately, it has been found that they had alcoholism initiated at approximately the same age even though they were raised in totally different environments. There was a much closer association between identical twins than fraternal twins in relationship to the onset of the disease of alcoholism. There are other studies now, for example, that are called prospective studies, in which the children, the sons of alcoholic fathers, in comparison to the control, the sons of non-alcoholic fathers, are given their first drink in a controlled situation and the son of the alcoholic father has an altered response to alcohol, right from the first drink. In fact, one of the things that happens is that they are able to push the level of alcohol up to a substantially higher dosage and this looks like a blessing in the beginning. In fact, what appears to happen is that there is a loss of the basic internal mechanism that relates to control. As I mentioned, this loss of control has a biological basis.

Well, what are we seeing? Joe can't be an alcoholic. He drinks everybody under the table. I've never seen him drunk. How can he be an alcoholic. Well, in fact, biological inborn high tolerance for alcohol may be one of the early signs of the disease of alcoholism. If you look back at the early historic AA literature, Doctor Bob, who was one of the cofounders of AA, said "I could always drink more than anybody. The next morning I didn't have nausea. In the beginning I thought that was a blessing. Now I realize that was a curse." That's a very graphic statement from one of the founders of AA as to what we're talking about in science.

Individuals that are addiction prone can have this altered response and some of the perception on the part of individuals that don't understand alcoholism is that they don't have a problem, because they have this high tolerance. They can drink anybody under the table.

This founder of AA also indicated that with his first drink an invisible barrier between he and the rest of the world disappeared. He learned to function better with alcohol. But now he realizes he was an alcoholic right from the first drink. What is the message that is given to TC graduates? Opiates are your problem. If you find that you really like alcohol, that's OK because it makes you more sociable, it makes you a more mature individual, because that's what the real world does. I suggest that that's a very dangerous message. That, in fact, the individual that is alcohol prone will like alcohol better, just like he'll like any other drug better, he'll have a more intense positive experience. And if they learn to like that drug, if they have this altered response, if they perceive a greater sociability and ease of social interaction, then in the long-term what you've done is set the stage for another form of addiction, in this case alcoholism.

In that context, I think it is very important that the therapeutic community movement look at the issue of alcohol, recognize that it is a very important factor in many relapses of TC graduates, it's a very significant issue for the therapeutic community movement, it's a very significant issue in the hierarchy of the therapeutic community movement. It is also an internal issue that puts it in conflict with other movements in the addictive disease field, for example; 12-Step Movement, Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, which is the support system for many TC graduates. You've got a real conflict if in the TC you're being taught the social use of alcohol and you go out and your network involves AA and NA, particularly NA in San Francisco which has a focus on a chemical-free philosophy. You've got a conflict there. You're going to cut that person off from one of the most valuable and important support systems.

I think, also, it is important that the therapeutic community movement educate itself on the signs and symptoms of different forms of addictive disease. I've already described this high tolerance, for example. Given the formula: "Addictive disease = Genetics + Environment" one of the things that we've learned is that alcoholics black out, non-alcoholics pass out. We used to think that blackout was a late stage of the disease of alcoholism resulting from brain damage. Now we know that it's a form of familial alcoholism with a high genetic profile in which the individual will manifest blackout very, very early in their drinking career. Blackout being a period of amnesia in which the individual retains gross motor control. I've been in sessions with TC graduates in which they got drunk and blacked out and nobody said anything about it. A blackout is a pathognomonic sign of the disease of alcoholism. Now that same TC knows very well the signs and symptoms of the disease of opiate addiction, but may not be updated on the current evidence as it relates to addictive disease of other types.

So, in this situation, I feel it's very important that there be an expanded alcohol education program for the therapeutic community movement, starting with staff on down to the graduates. I think it is very important that the TC movement leadership address the alcohol issue and deal with whatever is necessary, including intervention, with those current TC leaders who are actively abusing alcohol. Just because they have made a marvelous contribution to the therapeutic community movement does not mean that you should stand back and allo them to die from the disease of alcoholism. That's not a moral position. That's trying to save somebody's life.

I think that there needs to be a broader and more emphatic emphasis on abstinence from alcohol for some of the individuals in the therapeutic community, and as they graduate and move on to the community as a whole. And in that context that all these elements exist within TCs. I believe that these attitudes that we can't handle alcohol in the therapeutic community modality are more attitudinal rather than based on reality. The therapeutic community movement, the TC environment, with its structure, its setting, its emphasis on the group process, its focus on abstinence and recovery, is well-equipped to deal with the disease of alcoholism. But obviously, new information can not develop unless there is attitudinal change. This attitudinal change has to start within. The first thing we have to deal with is that the reward of graduating from the therapeutic community should not be to die from the disease of alcoholism. The reward of making a major contribution to the therapeutic community movement should not be a switch from opiate abuse to alcoholism. Both the leadership and the graduates of TC, in my opinion, would be best served if TCs evolved toward a chemical free philosophy. In that context, we would have to be very specific with the topic of this presentation. Can the ex-addict drink? That's the question that served as the topic of this presentation. Can the recovering addict drink? My opinion is that the answer is an emphatic no. The TC graduate who holds onto alcohol is playing Russian Roulette with his or her recovery, both in terms of the subsequent abuse of alcohol, and in terms of relapse back to the primary drug of abuse.

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Detox Brew

An herbal infusion of comfrey and mullein aids the detoxification of heroin addicts.

THE Herbalist MAGAZINE

For several years I have been working as a counselor in a drug program for heroin addicts. It seemed to me that many of the older approaches to the treatment of drug addiction were ineffective, so I started using herbs to help addicts detoxify from heroin and methadone.

I have a teapot in my office and usually brew up herbal teas instead of coffee. Occasionally a few of the addicts who I was counseling would express an interest in herbs and we would sit down and drink a cup of herb tea. This started to catch on at the clinic where I work, until in a short while many of the addicts were turned on to herbs.

Of all the herbal concoctions I have used in the past year working with heroin addicts, the most effective and successful combination for detoxification is one I call "detox brew". It is a mixture of comfrey, mullein, rose hips, spearmint, orange peel, and golden seal.

Comfrey is a unique herb with many uses. It aids in healing broken bones, serves as a poultice to draw out pus, and contains a lot of vitamins, minerals, and protein. However, the most relevant of its healing properties is in relation to the tonic to facilitate the healing processes involved in colds, runny noses, or sniffles, which are all common symptoms of detoxification. Since heroin and methadone depress the respiratory system, detoxification entails finding a new balance in respiratory functioning. The comfrey root or leaves in detox brew aids in this.

Mullein is a large plant with fuzzy pastel gray-green leaves. Made into a tea, it is an excellent healing aid for lung ailments such as asthma, bronchitis, or clogged sinuses. It has been used extensively in folk medicine as a home remedy for sore throats, coughs, and ailments of the upper respiratory system. A mixture of comfrey and mullein is effective in re-establishing healthy breathing, especially when addicts are detoxifying from methadone, an artificial narcotic used as

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ALCOHOL & THE TC GRADUATE: THE PERMISSIONS MODEL

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As Chief Executive Officer of Walden House and a staff member over the last 20 years in both an administrative and clinical capacity in a TC I have certain view points on alcohol and the *permissions* that clients take to use alcohol in the final phase of treatment which I would like to discuss in this paper.

I do not believe in the disease model for the drug abuser in the therapeutic community, although I think a lot of people in the United States are following that trend in their treatment modalities now, because of third party payment reimbursement. I truly believe that the alcoholic with alcoholism has an altogether different disorder than the substance abuser who uses heroin, cocaine or other opiates.

I do, however, believe in the permissions model and what I would like to do is to further explore what the permission model is. What I mean by the permissions model is: if you take someone that is in treatment and comes in as a heroin addict with little education and a minimum of social skills, and he participates in your residential treatment center for 18 - 20 months, gets his GED, and is getting ready to re-enter society, go on aftercare services and go on into hopefully becoming a good tax paying citizen, and he walks out of here and drinks, then he is very vulnerable for going back to his drug of choice, because he still has many re-entry issues to deal with and tasks to accomplish.

For example: What do you do on a Saturday night with a paycheck in your pocket? How do you deal with rejection? The whole resocialization issue comes up, and I usually ask "What do you do on a Friday night when you get rejected and how do you deal with that rejection?" You're in a bar and you ask someone to dance they say no. You ask another person to dance and they say no. So you go to the bar and you have 3 or 4 scotches which gives you permission to go and get a half gram of cocaine and ultimately leads to sticking a needle back in your arm. You're not dealing with a substance free re-entry and resocialization when you drink. One permission leads to another, and another, and then you fall.

The same kinds of things can happen working on a job and dealing with the boss. You have a lot of anxiety, starting a new career substance free, taking care of a home. How do you pay your phone bill, gas and electric bill? How do you budget yourself? How do you continue to get some education? How do you put all of these things into your life and lifestyle? I truly feel that during re-entry people are very, very vulnerable to go back ultimately to use their drug of choice and that they should be substance free. They should deal with all of these issues, continue to see our outpatient or aftercare people and work on these issues. Working on re-entry issues is the most valuable piece of treatment that clients have. It's the hardest time. The T.C. is just like a mothers womb. It's warm, secure, comfortable. You meet peers, you meet friends, you get to realize yourself, actualize yourself and when you go into the aftercare component you feel real alone. Its frightening, its a thing that you have never done before.

For example: take a person 30 years old who started using opiates at 13 and missed his whole adolescence. He never learned social skills, work habits, romantic foreplay, job skills and educational habits. He doesn't have any skills - he is a 30 year old adolescent that has to re-learn all of these skills and deal with all of these issues again, drug-free. You give him any kind of substance to use as a cushion, and it ultimately gives him an opportunity to take more permissions, distorts and changes his personality and rationalizations. And with alcohol there is drunk driving, violence, fights and permissions.

I would like to recall a story. My background is that of an ex- heroin addict out of the criminal justice system of New York. When I was in my mid 20's I was tired of using drugs and going in and out of prison systems. I wrote a letter to Synanon and I asked them, (this was 23 years ago) if I could come into their program, and I got a letter back from one of the directors, Reed Kimble, and he told me to get in touch with the Westchester County Parents Association, which I did. They had a weekend of bingo and raised $1,000 to send someone to Synanon, and low and behold, Alfonso was the bingo prize.

After my four year stay in Synanon in the early sixties, I left and became one of the fore-fathers of Delancey Street in San Francisco, California. After a one year stay in Delancey Street, I left and came to work at Walden House, and have been employed in every capacity, from counselor all the way up to the C.E.O. during the last 14 1/2 years.

I would like to recall a time around 10 years ago, when a good dear friend of mine had left Synanon and came to my home with his wife for dinner. At that time I was drinking and I offered him a glass of wine with our macaroni dinner. His hands started shaking, and I asked "What's the matter, John?" He answered, "Well you know, Al, if I drink this glass of wine, I am ultimately going to stick a needle in my arm". Now, there was something definitely wrong with relating a glass of wine to sticking a needle in your arm, especially to someone with an Italian ethnic background. The Italian culture, like most European cultures, has wine and beer at meals and this is part of the ritual of dinner. This is different from the American culture. My friend John said, "I will die" and ultimately he went back to drugs and died.

I think everybody is an individual and there are individual differences in regard to alcohol use and the TC graduate. He needs at least 3 years substance free in his re-entry after participating in Aftercare treatment before thinking about drinking any kind of alcoholic substances. The client that is in the therapeutic community for an 18 month period of time, and has been in aftercare treatment for 6 months to a year should not drink. He needs to experience some of the following things substance free: a relationship, marriage, divorce, separation, a job, up and down the ladder of the job, re-employment, getting his apartment together, getting furnishings together, getting his nest together and is stable in his nest. If he chooses to drink after having done all these things, then that individual should not look at himself as a diseased person for the rest of his life. But he should understand that as a client out of treatment he should not drink alcohol, that this permission could ultimately lead him back into his drug of choice, the criminal justice system or re-cyling back into the therapeutic community.

I do not have exact statistics on this, but I have been working in therapeutic community systems for the last 22 years of my life and believe myself to be an expert academician in substance treatment. I have seen many of my friends fall behind the permissions model alcoholism syndrome, and I've seen many clients that walked out of the T.C. and their reward was to go right out and drink alcohol.

I feel this is an important issue and I want to share this with my colleagues. I have been opiate free for the last 15 years of my life. I drank alcohol for many of those years and I have never abused alcohol. But I can recall several incidents in my re-entry when the alcohol gave me permissions. I'm not saying that Alfonso Acampora will never drink again because I am not a disease model individual. However, I am recommending that if our graduates chose to drink that they do so after a 2-3 year period of time under supervision and individual counseling to clearly monitor behavior and control.

If we would all close our eyes and think about the permissions alcohol can give, I know as a professional in this field, you would agree with me. Thank you very much for this opportunity. I will present further information and research at the 10th World Conference in Eskilstuna, Sweden.

FIRE-WATER: AN ARCHETYPAL PERSPECTIVE

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The Problem

The Native American psyche (soul) has undergone a tremendous wounding process since the Europeans first appeared on the horizon about 500 years ago. Presently, the wound has been searching for relief from suffering by anesthesizing the pain. The most common (and undifferentiated) attempt at healing the psychic wound has been through the consumption of alcohol, i.e., firewater.

The American Indian Policy Task Force has reported that the use of alcohol and other drugs is one of the most serious health problems facing Native American people today. The statistics reveal that nationwide arrest figures for alcohol crimes for Native Americans in 1972 were 12.2 times that of the non-Indian population. Figures for alcoholism also indicate a death rate of 51.9 per 100,000 which is about 5 times that of the non-Indian population. Suicide related to alcoholism is also very high as indicated by a survey among the Papago Indians, which showed a rate of 5 to 10 times the national average. In a report by Nolan (1978), the number for alcohol abuse had increased by 57% in a four year period (1974-1978).

The literature describing the immensity of the problem is abundant but no solutions have been given which have had a meaningful impact (otherwise the problem would be showing an amelioration and as the literature shows the problem is worsening). It is for this reason that this article will suggest some innovative explanations of the phenomenon of disproportionate alcohol abuse among Native people. It seems obvious that in order to heal the psyche (soul) one must search for a soul solution, and the notion of soul is closely associated to myth and myth is inseparable from the land. Therefore, it is rational to search for the soul or psyche in the images, myths, and projections of the gods and demons who emerged from the "native" land as is prescribed by analytic psychology.

Fire-Water as the Image of Conjunction

Present attempts at delivering services to Native peoples are irrelevant for the most part since those services have their genesis in orthodox European theoretical constructs. What the Native person needs in order to heal the problems and illnesses that plague him are conceptualizations of the healing process. For this reason, an affliction such as alcoholism needs to be addressed in a relevant way which makes use of Native symbols, myths, and images.

To accomplish a relevant treatment process the Native individual's traditional way of healing encompassed symbol, myth and ritual. In order to find what the Native psyche needs, one must then address the emerging symbols and images and it becomes necessary to find the meaning of primitive use of symbol to achieve relevance, i.e., unconscious symbols need to be assimilated into consciousness. In order to take a look at the symbolic soul of the Native it is necessary to look for it in places that have myths, symbols, and images available for present examination. To facilitate the search for mythological material, this writer had used material from Meso- America which is literally abounding with catalogued relevant mythological data. From Meso-America the notion of the conjunction of fire and water existed as images projected by the psyche. The most archaic image is that of Tlaloc who is related with water and at times there is also a relationship with fire. The deeper meaning that allowed for Tlaloc to emerge was that of the union of sun and rain in order to produce life on the earth (the conjunction of opposites is obvious). In the fresco Teotihuacan we find Tlaloc as the god of rain with a solar flower emerging from the mouth, and in another image we find the god of fire (Huehueteotl).

The union of opposites is apparent where the god of rain is seen with wings of a butterfly (which is fire) and with these is the symbol of movement and well being (swastika), which clearly indicates the union of opposites. The ancient Meso-American psyche was preoccupied with the notion of uniting matter with spirit, which is the relevance of the above images or myths. This notion is once more clearly seen when on considers the acts of a major divinity in Meso-America, i.e., Quetzalcoatl. After becoming drunk and committing a violation of taboo, he threw himself into the fire and his heart emerged towards heaven (transformation through the destruction of matter).

It has been shown that fire transforms matter in the ancient Native psyche. The trophy that the warrior was after, was the atl- tlachinolli (atl = water, tlachinolli = burnt) which is nothing else than his own soul.

This is such a basic notion that the Templo Mayor de Tenochitlan had the god or rain and the god of fire next to each other on the same pyramid- - there can be no other interpretation, i.e., two acts in the drama of cosmic union. The collective nature of this image becomes apparent when one looks closely at the Shiva Nataraja, which also reflects the union of opposites through the union of fire and water.

Archetypal Ramifications

It is apparent from the above notions that the Native soul has derived meaning from the union of opposites, and that the undifferentiated search for this conjunction may have been one of the reasons why such a psyche is so fascinated by fire-water (alcohol). The dual nature of the conjunction is close to the one found in analytic thinking in the images of the spirit of mercury, who personifies both the diabolical and the holy at the same time. The problem is in the individual identifying the positive side of the archetypal notion and to differentiate this into the conscious aspect of the individual's life.

When the words fire and water are examined it is obvious to see that they stand diametrically opposed to each other. Through the process of fermentation, the opposites are united to form a unity as in the making of alcohol (the fire from the sun and the water used to grow the plant or vine are united in the process of fermentation to produce wine). Therefore, it is apparent that this conjunction may serve as the object of projection for a psyche, which has recently experienced a separation of opposites brought on by a psychic disaster or trauma (such as was experienced in the conquest of the New World.

This separation in the psyche happened in the New World when the conquering peoples overwhelmed the psyche of the Native through the forceful imposition of mythology which was foreign and differentiated in a totally different fashion. While the Native was experiencing a participation mystique consciousness (oneness with the world and a more intuitive form of world view), the Western psyche was experiencing a more rational and technical consciousness (Logos) which stands diametrically opposed to the Native psyche. The Native psyche attempted to regress so as to escape annihilation. In other words, as soon as consciousness becomes too differentiated the unconscious attempts to overwhelm the psyche and return it to a previous state of harmony (where there are no opposites). This notion is clearly demonstrated when one looks at some oral traditions in an analytical way. The Popol Vuh, which is the oldest documented creation myth in the New World, demonstrates clearly that as more knowledge is gained there comes a destruction which attempts to revert the psyche to more primitive psychological state (this notion is also seen the world over in the numerous flood stories- - that is the unconscious overwhelming consciousness).

Since the total regression is impossible, the psyche is left with some of the previous consciousness or ego state. If we were to look at the previous whole of the psyche, then we could see that the previous whole has become split, i.e., part has regressed but part is still left in the conscious ego state.

This small part of consciousness is totally impotent in the face of the overwhelming opposite mythology, and therefore only serves as a place where the individual and collective psyche can remain painfully aware of the overwhelming onslaught of the new mythology which literally rapes the psyche (especially since Western world view is seen as more masculine (logos) by analytic thinking).

It is at this point that the psyche which is still in participation mystique consciousness immediately searches for a material object to project psychological contents onto. Not only will the psyche need a compensatory object, but the psyche will need an object which typifies the long lost conjunction or oneness with the world. The fire-water conjunction offers such an object; complete with the hermetic vessel in which the psyche can become contained as it anesthesizes itself into the illusion of being one with the world once more. Unfortunately, the projection into the vessel is undifferentiated or unconscious which immediately unleashes the shadow side of the compensatory object, i.e., the dark side of alcohol. At this point the psyche is contained in the bottle in what is literally a state of possession, which may require more alcohol to anesthesize the reality of the situation confronted, thus the problem becomes a complete cycle in and of itself.

The fire-water projection remains unconscious and therefore the small remaining consciousness becomes totally seduced and possessed by its own projection. This is made possible in part because while in participation mystique the unconscious is projected onto the object and the object is in turn introjected by the ego, which is what gives the individual the feeling that external object are animated while in this state. Therefore, the fire-water becomes charged with the contents of the unconscious which allows the fire-water to obtain a collective destructive (shadow) potential, which leaves what little ego is left to face annihilation. It is this destructive force that may be partly responsible for the destruction of the Native psyche in the past centuries.

For this reason, it is imperative that the Native psyche reverse the regression that occurred at that time and begin to pursue a more differentiated attempt at the union of opposites. The attempt at conjunction needs to be congruent with the environment that the psyche confronts itself with, otherwise the psyche will receive yet another wound. It is time that fire-water not be regarded as the source of the problem, but merely as the projected, undifferentiated attempt at restructuring of a fragmented psyche.

An image of a differentiated conjunction that uses fire and water is one of the Plains Indians' sweat lodges. In this healing vessel it can be seen how fire and water are united in order to create the union (steam), which is then used for healing purposes. Not that the sweat lodge is a panacea, instead it may be pointing out that since the psyche had been projecting fire-water as a conjunction, the sweat lodge may have the more positive, healing side of the dualistic process. If the psyche does not discontinue to project undifferentiated contents onto the fire-water, then the tension of opposites will continue to drive the person to the final conjunction, which may be manifested by death as postulated by analytic psychology (this notion may help in understanding the high suicide rate among Native people).

From the images that we find in Meso-America it seems as if the psyche was evolving in a normal fashion in its attempt to differentiate itself into a more conscious ego functioning psyche. The traumatic wound does not necessarily have to be the end of the struggle towards consciousness and the conjunction. It may even be viewed as an event that occurs in the development of nay individual thus allowing psychoanalytic theory to pave the way to the resolution of the fixation.

It seems that the unconscious has given the psyche the clue to the healing process from the beginning. It is no accident that our ancestors immediately coined the devouring fluid in the bottle by the projected image of fire-water. The psyche was at the same time giving the image of destruction, which when seen in the light of ego consciousness can also provide the image for healing and psychological conjunction. The psyche needs to unite the opposites in consciousness instead of projecting the unconscious into the bottle containing the fire-water. This method of healing will require that the mythical layer of psyche be allowed to emerge with its own healing images, as postulated by the analytic process in the works of Jung. If enough individuals can accomplish the union of opposites in a differentiated fashion, then a new collective myth can emerge for the healing of the Indian Nations.

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DESIGNER DRUGS: THE ANALOG GAME

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The term designer drugs was originally coined in the laboratory of Dr. Gary Henderson at the University of California at Davis. It was originally meant to refer to the increasing sophistication of chemists in illicit laboratories who are now approaching the ability to produce drugs designed to fit the tastes of individual clients.

Designer drugs are beginning to play a more prominent role in the heroin addict's market place. Fentanyl analogs are being sold as "China White" or "Synthetic Heroin", and are being asked for by addicts on the street. Availability and price are attractive to the heroin user, some who feel they may contain less adulterants than heroin.

Our data collection upon admissions to programs show an alarming increase of approximately 20% in the use of heroin as the primary drug by those 17 years of age or younger. Over 50% of all admissions to public programs in the State of California are for the primary drug of heroin.

Fentanyl

The fentanyls are a class of very potent narcotic analgesics originally synthesized by the Janssen Pharmaceutical Company of Belgium. Although the chemical structures of these drugs are quite different from the opiates and opioids: the fentanyls, nevertheless, possess all the pharmacological and toxicological actions of the classical narcotics. Fentanyl, the parent drug, is used extensively in clinical medicine as an intravenous analgesic anesthetic under the trade name Sublimaze(R) It is a well respected drug.

Beginning in 1979, illicitly synthesized derivatives of fentanyl began appearing on the streets as drugs of abuse under the name of "China White", the name usually associated with very pure Southeast Asian heroin. Soon thereafter a series of deaths occurred in southern California which looked like typical heroin overdose except that toxicological analysis failed to detect any narcotic. To date over 100 such deaths have occurred.

The laboratory at UC Davis, partially supported by the California State Department of Alcohol and Drug Programs, is using very sensitive analytical techniques specific for the fentanyls, and has detected various fentanyl derivatives in the body fluids of the overdose victims. In addition, they have detected the fentanyls in the urine of a significant number of individuals enrolling in various methadone and other drug treatment programs throughout California.

To date they have identified ten different fentanyl derivatives in addition to fentanyl itself in samples being sold illicitly under a variety of names such as China White, Synthetic Heroin and Fentanyl. The newest derivative, 3-methyl fentanyl, is extremely potent (approximately 3000 times as potent as morphine) and is thought to be responsible for an alarming number of recent overdose deaths in the San Francisco bay area.

Fentanyl Derivatives Used Medically

Fentanyl was introduced into the United States in 1968 as an intravenous analgesic anesthetic under the tradename Sublimaze(R) or Innovar(R). Fentanyl now occupies a major place in therapeutics as a preanesthetic medication, an anesthetic, and a post-surgical analgesic. Fentanyl is very potent (approximately 100 times as potent as morphine) and short-acting (duration of action is approximately 70 minutes). It is a very important drug clinically and is probably used in over 70% of all surgeries in the United States.

Sufentanyl is an extraordinarily potent derivative of fentanyl (2000-4000 times as potent as morphine) used as an anesthetic analgesic agent for cardiac surgery. Alfentanyl is a very short acting (15 minutes), slightly less potent derivative (20-30 times as powerful as morphine) currently utilized in clinical trials as an ultra-short acting analgesic to be used in diagnostic, dental, and minor surgical procedures.

Lofentanyl is extremely potent (6000 times as potent as morphine) and very long acting. It is being evaluated for use when prolonged analgesia and respiratory depression are required such as in tetanus and multiple trauma. Carfentanyl is a very potent analog of fentanyl (3200 times as powerful as morphine) which is used only in "capture guns" for immobilizing wild animals.

The Illicit Analogs of Fentanyl

Very little is known about the biological effects of the illicit derivatives of fentanyl. At best only preliminary data is available from studies conducted in laboratory animals. Virtually nothing is known about their effects on man.

Alpha-methyl fentanyl was the first illicit fentanyl derivative to appear on the streets. It is a very simple modification of the fentanyl structure and is about 200 times as potent as morphine. As a new drug entity, it was not at first on any international, federal or state restricted drug list and was in essence "street legal." However, it is now classified as a Schedule I drug (no approved medical use and high addiction liability) by the Drug Enforcement Agency of the United States.

Para-flouro fentanyl was the second illicit analog of fentanyl to appear on the streets. It is a very simple derivative of fentanyl and has about the same potency. It is presently classified as a Schedule I drug by the D.E.A. Little is known about this compound. It appeared only briefly and does not seem to be in use at this time.

Alpha-methyl acetylfentanyl first appeared on the streets in 1983. This also is a very simple derivative of fentanyl, but because technically it is a new chemical entity, it escapes classification as a restricted drug. At this time it is not a restricted drug. Nothing is known about its pharmacological properties.

Benzyl fentanyl has recently appeared on the streets mixed with other fentanyl derivatives found in samples analyzed by the laboratory at UC Davis. It is possibly an unwanted synthetic byproduct or an intermediate used in the synthesis of other fentanyl derivatives. It has no narcotic effects.

Fentanyl itself has appeared in street samples and has been associated with overdose deaths in California. It is most likely that the fentanyl sold on the streets is synthesized in illicit laboratories and not diverted from pharmaceutical supplies. All fentanyl sold on the streets is in powder form, and all fentanyl sold as a pharmaceutical is in dilute liquid form. Abuse of Sublimaze(R) in hospitals and clinics by medical personnel has been documented but the extent of the problem seems to be known.

3-methyl fentanyl is the latest derivative to be introduced onto the streets and it is certainly one of the most potent of the fentanyls (3000 times as powerful as morphine). This analog appeared in California sometime between the fall of 1983 and the spring of 1984 and is thought to be responsible for over a dozen deaths in the San Francisco bay area, the highest incidence of fentanyl related deaths to date.

Fentanyl and its analogs are cut (diluted) with large amounts of lactose or sucrose (powdered sugar) before they are sold on the street so the amount of active drug present is exceedingly small, less than 1%. These amounts are so small they contribute nothing to the color, odor or taste of the sample.

The color of the samples obtained to date has ranged from pure white (sold as Persian) to light tan (sold as China White, Synthetic Heroin or Fentanyl) to light brown (sold as Mexican Brown). The brown color comes from the lactose which has been heated and has caramelized slightly. The textures of the samples observed in the laboratory has ranged from light and finely powdered to somewhat coarse, cake-like and crumbly, somewhat resembling powdered milk. Occasional samples will have a medicinal or chemical odor, but this is not characteristic.

Intravenous injection is the most common route of administration for the fentanyls: however, they also may be smoked or snorted. In fact, because of their high lipid solubility, the fentanyls should be excellent drugs for snorting and may become increasingly popular among cocaine users. At least one overdose fatality was identified in which snorting was the only route of administration. We have also been able to detect fentanyl in the urine of individuals who used the drug only by smoking it.

In summary, the fentanyls appear in all the various forms that heroin does and there is nothing characteristic about the appearance of any sample that will identify it as fentanyl.

Pharmacological Effects

It should be remembered that although the fentanyls are chemically quite distinct from other narcotics such as morphine, heroin and methadone, they are pharmacologically equivalent; that is, they have all the

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effects, side effects and toxic effects of the classical narcotics. Therefore, all the actions of the fentanyls can be reversed by naloxone, although higher doses of this narcotic antagonist may be required.

The euphoria or "rush" from the fentanyls should be qualitatively similar to that of heroin and the intensity of the effect would depend upon the dose and the particular derivative used.

Profound analgesia (absence of pain) is a characteristic of all the fentanyls. As little as 50 micrograms of fentanyl will produce analgesia while only 3 micrograms of the 3-methyl derivative would be required.

Respiratory depression is the most significant acute toxic effect of the fentanyls. The depth and duration of respiratory depression will depend on the dose and the derivative used. However, compared with other narcotics, this effect is relatively short-lived. For example, following 200 micrograms of fentanyl given intravenously, maximum depression occurs within 5-10 minutes, and normal respiration returns within 15-30 minutes. The narcotic antagonist drug naloxone, whose trade name is Narcan(R), is the antidote of choice for respiratory depression and other side effects produced by the fentanyls.

Fentanyl also produces a dose-dependent decrease in heart rate of up to 25% with a parallel drop in blood pressure of up to 20%. This effect is thought to be due to vagal stimulation and can be blocked by atropine. The role of this response, if any, in overdose deaths is not known.

Muscle rigidity, particularly in the chest wall, sometimes called "wooden chest" is a response common to high doses of all narcotics. Individuals using the fentanyls may describe this effect as a muscle tightness or tingling.

The fentanyls produce both tolerance and physiological dependence following repeated administration. Controlled studies have shown that addicts perceive fentanyl as having heroin-like effects. In California, we have found many individuals enrolling in methadone treatment programs who have only fentanyl in their urine upon admission, yet are convinced they use only very high grade heroin. Therefore, when pharmacologically equivalent doses are used, most users probably cannot differentiate between heroin and the fentanyls.

Abuse Potential of Fentanyl

Fentanyl as a pharmaceutical drug was always thought to have a low abuse potential because of its short duration of action and its restricted availablity. Also, it is available only in injectable, aqueous formulations containing either 100 micrograms or 500 micrograms per vial. These relatively small amounts and low concentrations make it difficult for an addict who has reached a level of tolerance of opiates to administer a euphoric dose conveniently.

Until now, the only documented illicit use of fentanyl was in "doping" race horses. Narcotics are frequently used to dope horses because they produce excitation in the horse (and other animals such as the cat and mouse). Fentanyl's short duration of action and its very low, difficult to detect concentrations in blood and urine make it an ideal doping agent. Fentanyl has been used in this manner for nearly a decade.

Now the fentanyls are available throughout most of California and because they are potent, not detected by routine analytical methods, and, in the case of the newer analogs, quite legal, they may become the drug of choice for many heroin users. It is our opinion that fentanyl use will increase in California, its use will spread to other states, and that new derivatives will appear periodically.

Overdose Deaths

To date the laboratory has identified 100 overdose deaths caused by the fentanyls. Nearly all of these cases occurred in California. However, two recent overdose deaths in Oregon suggest that fentanyl use may be spreading to other states. All cases were similar in that they involved known heroin users, injection sites and accompanying paraphernalia. Autopsies showed typical signs of narcotic overdose such as pulmonary edema and congestion. Routine toxicological analysis of the body fluids revealed no narcotics, sedative or stimulant drugs present. However, analysis of these fluids in the laboratory using methods specific for the fentanyls revealed very low levels of these drugs. Traces of the fentanyls were also found in the accompanying paraphernalia.

Fentanyl-related deaths have occurred in nearly every urban area in California, in suburban areas, and even in semi-rural areas. Ages of the victims ranged from 20-49 years. Most were male, although 9 were female. Most of the victims were white, but there were significant numbers of hispanics and blacks. In short, fentanyl use is not confined to any geographical area or any social, economic or ethnic group, but is distributed widely throughout the heroin using population.

The fentanyls are very difficult to detect either in body fluids or paraphernalia because the amounts present are very small and because they do not react with the reagents routinely used for the analysis of narcotics.

A New Public Health Hazard

There are several clear-cut reasons. First, these drugs do not require importation and all the costs and expenses thereby incurred. Secondly, they are much less expensive to make. Thirdly, of course, those making and selling synthetics may not be prosecuted because the substance may not be illegal. Fortunately, the D.E.A. has recently been able to take swift action to control some of these substances. Let me give some examples. It is estimated that a single chemist working an eight hour day could, using the more potent fentanyl derivatives, supply the entire nation's heroin supply on an on-going basis. A single 6 month supply for the United States could be stored in a closet. Hence, one can see the immense attractiveness of this approach in terms of cost and liability to those on the production side of the illicit drug market.

What are the hazards? There are three basic hazards. First, these chemists are obviously not required to carry out safety trials with these new compounds as a legitimate drug company would. Hence, the first subjects to receive the new chemical compounds would not be laboratory animals, but human beings on the streets of our cities. Secondly, there are no quality controls in these laboratories as there would be in a legitimate drug company. Hence, contaminants or unwanted compounds are not removed, and probably often not even detected. Thirdly, there is the issue of potency. The fentanyl analogs, for instance, must be cut in microgram amounts. This is a tiny amount; a postage stamp weighs about 60,000 micrograms. Hence, overdoses are common, and the fentanyl series has been held responsible for at least 100 deaths in California so far. In essence, young drug abusers who take these new synthetics are playing Russian roulette. Only it is not lead bullets that they are aiming at their brains, but chemical ones.

Parkinson's Disease Side Effects

Given this scenario, one would predict it was only a matter of time before a true poison hits the streets. This is precisely what happened in northern California in 1982, when a highly toxic compound known as MPTP was circulated. This compound is neurotoxic to a group of cells in the brain known as the substantia nigra. By pure coincidence, this happens to be the same area that is damaged in Parkinson's Disease. We saw a group of young adults two years ago come to the Santa Clara Valley Medical Center who resembled in every way elderly patients with end-stage Parkinson's Disease. These young addicts had literally frozen up overnight, and were totally unable to move or talk. Treatment with anti-Parkinsonian therapy was probably life-saving in three cases. However, these patients continue to be severely disabled and require medication every one to three hours just to be able to move and eat or drink. Two of them have recently undergone prolonged hospitalizations and the outlook for their futures must be considered extremely grim.

While there are currently only 20 severely involved young adults who have been permanently crippled by this first "designer drug disaster", we have now identified an additional 500 people who were exposed to MPTP thinking it was a new "synthetic heroin." My estimate is that we have just been scratching the surface so far, and that there are at least one to two hundred more. Why are these additional individuals important? Because we now have evidence that damage to this area of the brain, even if it is not enough to cause symptoms at first, may act like a time bomb, with changes in the brain slowly ticking away. In other words, sooner or later, these young adults could come down with a Parkinson's Disease-like state. Up until now, this concern was just theoretical. But in the last several months, we have started seeing a group of young people at Santa Clara Valley Medical Center who used MPTP two years ago and who are just now starting to develop a myriad of symptoms, all suggestive of early Parkinson's Disease. In short, what we may be facing is an epidemic of Parkinson's Disease in young adults in northern California as a result of this catastrophe. The cost to society, not to mention the human suffering, could be immense.

I bring this entire phenomenon to your attention for a number of reasons. First, I see it as a tremendous potential hazard in terms of dealing with and combating the drug problem among our youth. Ways to deal with this phenomenon and hopefully slow or stop it must be studied now. Secondly, the costs in terms of a public health hazard have now for the first time become clear with this first designer drug disaster. The Parkinson's cases may only be the first wave of drug abuse to cross over from current treatment modalities to full, long term inpatient or maintenance type medical care. The cost of treating severely afflicted patients may see medical costs skyrocket to between $10-20,000 per month depending on the individual case. Thus, the medical economics of designer drug use is another dilemma that government must confront.

We need help and assistance in dealing with what may be an on-slaught of young people with progressive neurodegnerative disease as a result of this. Further, it seems extremely important to study and try to understand this first catastrophe with the ideas of developing techniques and ways to deal with future ones which almost surely will occur given the popularity of this new approach. We have already discovered at east one patient who has an entirely different neurological syndrome characterized by movements closely resembling Huntington's Chorea which have completely disabled him. there are also reports that there is a new PCP "designer drug" which is toxic as well. While traditional street drugs pose a major public health problem and need to be dealt with, I believe this is an instance where attention to a developing and potentially even more serious phenomenon is fully warranted now to prevent a much greater problem in the future.

Summary

Economic and social costs must be considered an important part of all discussions regarding synthetic drugs, especially because some of these drugs, like MPTP, can cause neurodegenerative diseases. Many of these patients require frequent hospitalization including intensive care became of the need to stabilize through therapeutic doses of medication.

Some of them, the more severely affected, will require long term and constant nursing supervision, a most costly endeavor. We cannot escape the irrefutable fact that we have before us, a problem of serious medical and economic gravity. Significant costs will obviously arise from needed law enforcement and treatment programs as the problem's severity intensifies.

The training needs for both law enforcement and the treatment network must be addressed immediately. Without appropriate training these institutions cannot mitigate this emerging problem.

Laboratories play an essential role in our ability to detect the fentanyl analogs in urine. Currently, we have only one laboratory in California with the expertise to do this. Under the guidance and supervision of Dr. Gary Henderson at the University of California, Davis, work has continued for the last four years to establish a routine test for the analogs of fentanyl. Most laboratories can test at parts per million. With fentanyl testing we are talking about parts per billion in body fluids, hence the difficulties. The State of California's Department of Alcohol and Drug Programs will continue to support this work which is of national importance.

I would state emphatically that the use of fentanyl analogs is already spreading throughout the United States. Until we have a network of more sophisticated laboratories, we will not be able to track or understand the scope and magnitude of the developing problem.

The domestic production of new, potent synthetic drugs will be the major drug abuse problem in the future. As efforts to control natural products such as opium, coca and marijuana become more successful, and as safeguards to prevent the diversion of pharmaceuticals become more effective, there will be more incentive to the illicit synthesis of drugs like fentanyl. New synthetic drugs will appear which will be more potent and more selective in their action. Smoking and snorting these drugs (routes of administration difficult to detect) will become more popular. The use of the new synthetics will spread to other states and countries.

The low risk of detection of designer drugs will stimulate their use in populations such as prisoners, parolees and military personnel. Less sophisticated laboratories will attempt to make fentanyl derivaties, thus increasing the possibility of toxic by-products. In addition, it is predicted that families of other drugs of abuse like cocaine and the hallucinogens will be synthesized and appear on the streets. In short, in the future, drugs of abuse will be synthesized domestically from readily available chemicals.

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Note: This paper was originally presented by the author as testimony to the United States Senate Subcommittee on Children, Family, Drugs and Alcoholism, Senator Paula Hawkins, Chairman, July 25, 1985. Legislation was subsequently adopted to curtail the manufacture of designer drugs.

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United States Senate
COMMITTEE ON LABOR AND
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WASHINGTON, DC 20510

July 11, 1985

Alfonso Acampora
Executive Director
Walden House, Inc.
815 Buena Vista Ave. West
San Francisco, CA 94117

Dear Mr. Acampora:

Thank you for inviting me to the 9th Conference of the World Federation of Therapeutic Communities. Unfortunately, my schedule will not permit me to attend this auspicious event.

Since I am vitally involved with families, children and the problems of drugs and alcohol, I commend the Conference for hosting this extremely significant event and worthwhile endeavor. It has also not escaped my notice the wonderful work being done in these areas by your facility. The State of California can consider itself fortunate to have a Walden House in its midst.

Congratulations to the World Federation of Therapeutic Communities. I wish success and know the benefits to be derived from this get-together will be immeasureable.

Sincerely,

Paula Hawkins

Paula Hawkins
United States Senator
Chairman, Subcommittee on Children,
Family, Drugs, and Alcoholism

PH/rlp

TREATMENT OF COCAINE DEPENDENCE WITHIN THE TC SYSTEM

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Introduction

The treatment of cocaine dependence is perhaps the hottest topic in drug treatment in the United States today. The continued escalation of use on the part of the general public and the dramatic increase in clients seeking treatment has made new demands on our treatment systems. Drug and alcohol treatment providers alike are focussing their attention on what needs to be incorporated into their existing programs to meet the specific needs of these clients. In addition, the conversion of large segments of the South American economy to cocaine production and the development of strains of the plant which mature faster and can be grown in more diverse geographical areas, has led to a continually increasing production which in turn stimulates the search for new markets (Cohen, 1985). Consequently, treatment providers can expect an increase in the number of clients presenting with cocaine as their primary problem.

Areas of this country and the rest of the world which do not now experience much of a problem may well see a dramatic change within the next few years. Across the United States, therapeutic communities have seen an increase in admissions for cocaine as the primary drug, and economic factors alone would be sufficient to produce this same situation in countries currently less affected. Since a well run therapeutic community often comes to be viewed as "the expert" in drug treatment within a community, it is not surprising that both users and those concerned about them are turning to these programs for help. Programs that can respond to their needs not only have an opportunity for a creative challenge, but also a chance to broaden their funding base at a time when tax dollars are steadily disappearing.

Cocaine users present an interesting challenge to the therapeutic community system, because there is a large subgroup among them with somewhat different characteristics than have appeared in the past. Addressing their needs requires that we distill the effective elements in the treatment process and combine them in new ways. The two most significant areas of focus are shortening the length of the residential stay, and strengthening the oupatient components of the program. There is reason to think that the length of stay in the residential stage of treatment can be different for many of these clients, and that outpatient services need to be enhanced to increase effectiveness.

Old and New Populations

Some of the clients admitted for cocaine problems share a very similar profile to those whose primary problem is with opiates. Often, these are dealers, or people who derive most of their income from dealing; people who have lost their jobs and do not have particularly marketable job skills; polydrug users with a preference for cocaine. A high degree of enmeshment in the drug culture and a relative absence of adaptive resources are major determinants of the degree of rehabilitative effort which will be necessary. Such clients are entirely appropriate for the long term commitment required by the majority of programs.

A second population has emerged with different characteristics from those previously seen in large numbers in the therapeutic community. This population has been described by Mark Gold and others from data collected from the national cocaine hotline, 800-COCAINE. Although this sample is skewed (one can speculate that non-white, non-middle class users would be less likely to use a national hotline), it does offer a picture of a newer population now seeking treatment. This group is making increasing requests at a wide range of programs: short term inpatient programs formerly devoted entirely to alcohol treatment, outpatient alcohol and drug programs, and residential therapeutic communities.

As described by Gold (1983), these users were on the average age 30, with an average of 14.5 years of education. They were employed, though many reported job problems, with an average minimum legitimate income of $25,000 per year. Most had never been arrested for anything, but reported "turning themselves into criminals" to support their habit. More than 25% reported they had stolen from family, friends, or their workplace to support their cocaine use. Many sought jobs in which it was easy to steal, or turned down promotions to remain in a position where stealing was relatively easy.

More recent hotline information supplied by Gold (U.S. Journal, May 1985) indicates a slight downward trend in age and income level and some troubling data about the use of cocaine in the workplace. In his recent sample, 75% reported they regularly used at work, with 48% reporting they sold or distributed cocaine at work; 64% believed the quality of their work was poor due to cocaine, with 18% admitting having job accidents due to use. A sizeable proportion, 39%, feared the health effects of a raise or promotion. Thus it is not surprising that Employee Assistance Program (EAP) referrals are common, with emphasis on short term stays and rapid return to the work situation.

When is Residential Treatment Appropriate?

Cocaine use often produces such a dramatic family and/or job related crisis that it is not surprising that many assume some form of inpatient or residential treatment is mandatory. However, the rate of relapse after the short term hospital programs appears to be very high, for reasons which will be examined later. In addition, many, if not most clients who still have their jobs will be unable or unwilling to make a commitment to a one year residential program. The appropriate treatment response may well be for therapeutic communities to offer a continuum of care, with the possibility of a relatively short term stay (30-90 days), and an intensive outpatient model either as phase II or a complete treatment. In such a model, the client could participate daily in outpatient activities, including education, family work, and group counseling. Even when the client has been through the residential settings, the key to reducing the rate of relapse may well lie in providing multiple weekly treatment contacts and an enhanced support system during the first three months in which the client re-enters the setting in which the triggers and stressors are present. It is this more highly developed set of outpatient services that therapeutic communities have the potential to offer, but do not now generally provide. Structure appears to be the key ingredient in successful drug treatment despite variations in our individual theoretical persuasions. The challenge of outpatient treatment is to create that structure, which is based far more on voluntary compliance in the outpatient setting. This paper will focus in some detail on what this outpatient model needs to include.

An extended stay in a protected setting is under certain circumstances a necessity, and in this context it is important to assess whether a medical (hospital inpatient) facility is advisable. In many cases, it is not the medical intervention but the protected setting which is sought, and therapeutic communities certainly can provide that at considerably lower cost. Some form of residential treatment is appropriate to consider in the following situations.

1) Client is homocidal or suicidal. Many cocaine users feel suicidal and the clinician must carefully assess the level of risk, and the quality of the support system if outpatient treatment is being considered. More will be said about a support structure for outpatient later.

2) Client is acutely psychotic. The cocaine-induced psychosis clears quickly once use is stopped, and some programs may be able to handle this on a short term basis, with clients in whom there is no history of psychiatric disorder.

3) Multiple drug dependencies. If these involve heavy sedative use, a medical setting may be appropriate. If the client has been a heavy alcohol user, with a history of delerium tremens in previous withdrawal episodes, a medical assessment is a must.

4) Client has a history of multiple outpatient treatment failures.

5) Client is incapable of combatting drug hunger on an outpatient basis, and it is necessary to eliminate access for a period of time.

Under these circumstances, a period of time in a residential setting can play a very important role. However, when the stay is short term, it is important that this period be viewed as the launching platform for a long term recovery process, rather than the occasion on which some magical transformation will take place. The disappointment in short term inpatient programs frequently stems from their failure to fulfill unrealistic expectations, rather than shortcomings in their actual offerings. The very term "aftercare" reflects this. Outpatient services which follow the residential experience are frequently viewed as something tacked on after the main event, and many clients assume their participation is more optional, especially if they feel they "did well" in the inpatient program. One must certainly ask if it is not the failure of the inpatient programs to provide more individually-tailored support in the post-residential stage of treatment, which accounts in large part for the high relapse rate. Therapeutic communities share a similar vulnerability. The longer residential stage is an advantage in separating the person from a drug using environment, but this also serves to insulate the client from triggers and stressors, and thus foster a false sense of security. With the traditional population served, it is appropriate to work towards removing the client from the drug using environment, which often involves predominantly criminal activities. With the newer population, however, one is often faced with highly skilled. Possibilities of job transfers are limited when people have highly developed technical skills, and such transfers by no means guarantee a drug free environment. Hence the problem of dealing with frequent temptation needs to be addresed.

Therapeutic communities, with their longer time frame, can afford to be more ambitious about the changes which can take place in the residential phase of treatment. However, it is still necessary to address the tasks of the early outpatient stages of treatment, particularly when the residential phase is dramatically shortened. In some cases, there may be no need or no possibility of a residential stay at all. The task facing many programs wishing to broaden their base is to strengthen their outpatient components. Following are some key ingredients in successful outpatient treatment.

Stages in Outpatient Treatment

The Crisis

It is important to have a clear idea of what brings the person to treatment at this time. This information can be crucial in identifying the leverage which enables the program to engage the person in treatment. Significant others who have brought pressure to bear on the individual may be appropriate to engage in the treatment process. More and more clients are coming to treatment as a result of Intervention (Cocaine Connection, Spring 1985; Wegscheider, 1981). Many outpatient programs are offering a modification of this service, in which family members and signficant others are helped to strategize on how to get the user into treatment. The motivation of significant others diminishes quickly once the crisis is resolved, so it is important to engage them immediately. The alcohol treatment literature suggests that involving the family may be the key to improving retention with at least the socially stable group of clients, especially on an outpatient basis.

The Detoxification Stage

Whether the person is in a residential facility, or in outpatient treatment, they will go through a period of detoxifying from cocaine and other drugs. An appreciation of the range of withdrawal effects will enable the clinician to be responsive during one of the most vulnerable periods of treatment. Typically, major client dropouts occur during the first 30 days of treatment. The client who remains in treatment through this period improves his or her chances of a positive outcome. Clients who are ambivalent about the treatment process or about establishing specific treatment goals are often nonetheless eager to talk about the effects of the drug, and this can be a means of engaging them. The counselor who has specific information about health and psychological aspects of cocaine can use this as a tool to establish a working relationship with the client. It is important that expectations be appropriate to what the client can handle, as dysphoria and confusion are characteristic of the detoxification process. Some counselors respond to client ambivalence by aloofness or irritation, and do not take advantage of this crucial bonding period.

It is also important to remember that nobody uses only cocaine; it is almost always used in conjunction with at least one other drug to "cut the edges." Alcohol is certainly the most common, but others often used include valium, marijuana, and to a lesser extent, opiates. Clients tend to underestimate and underreport use of these other drugs, so a full drug screen on admission provides essential information. The counselor needs to be alert to withdrawal symptoms from alcohol and other drugs. Overuse of alcohol for lengthy periods of time can produce impairments of attention, concentration, and short term memory which is often mistaken for resistance to feedback and insight in the newly abstinent client.

Education and supportive counseling during the detoxification period plays a crucial role in engaging the client in the treatment process. Information about the effects of the drugs and the potential withdrawal phenomena are enormously helpful, especially when used to generate an individualized detoxification plan. Ingredients of a plan which can be used in an outpatient setting are:

I. Physical

A.) Exercise is thought to accelerate the detoxification process and get the client mobilized more quickly. Regular aerobic exercise 4-5 days a week, at a scheduled time, is recommended.

B.) Diet needs to be balanced and wholesome and meals need to be regular. It is common for cocaine clients, once they resume eating, to unwittingly adopt a pattern that produces rushes and crashes similar to drug use. This stimulates drug hunger and prolongs discomfort.

C.) Vitamins. A high powered B vitamin supplement and vitamin C is helpful to most people. The amino acids tyrosine and tryptophan are neurotransmitter precursors which are increasingly recommended. These are hypothesized to speed the replacement of dopamine, norephinephrine, and serotonin which are depleted during cocaine consumption. (No systematic studies currently exist on this.) They are available in health food stores.

II. Psychological/Interpersonal

A.) Clients are urged to make out a detailed schedule of activities which includes exercise, therapies, support groups, etc. The goal at this time is ten drug free days.

B.) Clients are urged to line up their support structure, especially their non-using friends, and make clear to them what they are trying to do and what they will need. They are also urged to create some peer pressure to reinforce abstinence by announcing what they are doing, placing bets, etc.

C.) Clients are urged to list their hazardous situations, and problem solve with their counselors about these.

D.) Urinalysis can provide a powerful support structure in helping a client remain abstinent. Clients make a contract to give urine only if they are drug free. (Full screens are used for this.) Urine schedules appropriate to their drug(s) of choice are worked out with the counselor. This helps restore compromised credibility.

E.) Clients may make a list of consequences if they do not stay free. These need to be specific. For example, the client makes out donations to the IRS which get mailed upon result of a positive result. High stakes contingency contracting (e.g., letter to licensing boards) should always be done in collaboration with a supervisor or agency manager.

F.) Clients are asked to check out 12 step recovery group meetings until they find a group they like. Counselors need to be attentive to resistances to using this support system. AA groups may be preferred over NA or CA groups in a particular community. It is useful for the program to keep track of feedback on this subject and make recommendations accordingly.

G.) Clients are encouraged to identify leisure activities they used to enjoy without drugs, or ones they always wanted to explore. Cocaine users often describe a somewhat subtle flattening of affect that lasts long after the obvious "crash" during the initial period of abstinence. They need to be reassured that this is common, can be modified with exercise, and that their capacity for pleasure will gradually return.

Establishing and Consolidating Abstinence

This stage of treatment overlaps with the first, and begins in earnest as soon as the client has become sufficiently drug free for issues to be meaningfully addressed. Achieving abstinence can be viewed as a psychoeducational task, which involves understanding the how and why of abstinence, short and long term physiological effects of drug use and withdrawal, dealing with drug hunger (Zackon, 1985) and accepting the identity of a recovering person.

The two most common resistances are the tendency to downplay the importance of abstinence from the secondary drugs the client has been using, and the tendency to withdraw energy and commitment from the recovery process prematurely. Clients who consumed alcohol or other drugs without problems prior to their cocaine use are sometimes inclined to rationalize their continuing use of these drugs. Any use during the vulnerable period of early recovery has the potential for undermining judgment, often leading to a slip back into cocaine use. In addition, clients often develop severe problems with their secondary drugs, but their denial mechanisms are at this time so highly developed that this passes unnoticed. Marijuana and alcohol seem to inspire the most adamant resistance; marijuana because it is still frequently seen as harmless, and alcohol when it has not appeared to be a problem in the past. We recommend the client make a commitment to abstain from the use of all intoxicants, not just illegal ones, for a period of six months, which generally provides enough time to assess the issue more thoroughly. Resistance to making this short term commitment can much more easily be handled as ambivalence about the recovery process in general, as most clients view it as a sensible practice. Our long term recommendation to people is that in view of the mounting clinical data on cross-addiction, total abstinence provides the widest margin of safety, but this is much more readily accepted by clients in the later stages of recovery.

Cocaine is a short acting drug, and it is remarkable how rapidly clients begin to look better and return to normal functioning once they become abstinent. It is this very phenomenon that appears to make it easier for them to conclude they have the problem resolved and do not need to continue to invest time in activities connected to the recovery process. However, cocaine users describe a very similar pattern of episodic flareups of craving and early withdrawal symptoms as alcoholics. The risk of relapse is particularly intensified at this time (Erlich, 1985). Involvement in a cocaine recovery group can be invaluable at this point.

Such a group fosters early identification of warning signals and useful strategies for coping. Like family work, it is a crucial part of treatment.

A major task of this stage of treatment is making the major life style changes needed to support abstinence. The longer the client has been absorbed with cocaine use, the more extensive the task of regenerating a social and support network of non-users. When cocaine use is intimately tied to the workplace, this endeavor can be even more difficult. Clients usually encounter a fair amount of negative feelings about their behavior during their drug-using periods. Taking responsibility for this without self-recrimination is a delicate task. Urinalysis can be particularly important for restoring credibility with intimates at this phase. It relieves anxiety on the part of significant others and protects the client from the discouraging experience of being mistrusted even when doing well.

Relapse prevention is an important part of the work at this stage. In conjunction with a research project, Alan Marlatt and Terence Gorski worked out a classification system of situational and emotional factors present in relapse episodes. Previously, programs avoided discussing relapse, in part out of a desire to avoid sending failure messages to the client. When clients are asked about what precipitated a relapse, their responses fall into three categories: 1. negative mood states, such as anger, boredom, and loneliness; 2. interpersonal stress, such as arguing, being criticized; and 3. social pressure situations. By examining the relapse in detail, clients can be helped in identifying specific vulnerabilities, and problem-solve around them. In addition, clients are encouraged to distinguish between a "slip", one use, and a relapse, a continuation of use. Resistances to reaching out for help are very important in confronting these issues. Cocaine recovery groups are an ideal place for this exploration to take place, as other group members are adept at identifying triggers, actions reflecting a set-up for use, and strategies for overcoming these difficulties.

Psychological Exploration

Drug treatment is often mistakenly characterized as not dealing with psychological issues until very late in the recovery process. In fact, the skilled clinician will be using psychodynamic savvy at every stage in the process; however, the focus or goal will be more circumscribed than in insight oriented therapy. It is generally considered appropriate to tackle highly charged psychological issues in earnest only when abstinence is very solidly established. This includes problems of developmental arrest, particularly in clients with a long history of drug use, and the relationship between intolerable psychological states and addiction. It also includes work on traumatic events such as incest, child abuse and molestation, and other forms of brutalization. These will of course come up early in the treatment, but serious attempts at resolution must be postponed in order to be effective. Although the client may continue this type of work with a conventionally trained mental health therapist, an understanding of substance abuse issues is greatly advantageous because of the increased danger of relapse during this kind of work, particularly if the therapist's sense of timing is not finely tuned.

In summary, programs that wish to address the needs of the newer cocaine using population seeking treatment need to focus their creative efforts on the outpatient phase of treatment. In this model, the inpatient stage is seen as the launching platform for the recovery process, rather than the time period when the major transformations will occur. The task is to find ways to build structure in the outpatient treatment, adequate to the changing needs of recovering clients. By so doing, programs will enrich their offerings to their existing components, and most likely improve the potential of a long term successful outcome for everyone.

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HERBS AND ALTERNATIVE HEALTH IN THE TC

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The use of herbs is a fascinating phenomenon in the treatment of substance abuse. Herbs are natural botanical substances which have noticeable effects on the human organism. Throughout the history of mankind, herbs have been eaten for nutritional and healing purposes as well as for getting high (Nebelkopf, 1981).

The practice of healing with herbs is an ancient art. The earliest treatise on herbalism was written in China over 5000 years ago. In ancient Greece, Hippocrates, who is regarded as the father of modern medicine, wrote extensively about herbs and their applications to medical treatment, particularly in conjunction with diet, fresh air and physical exercise. During the Elizabethan period in England, herbal medicine reached a peak from which much of our present-day herbal lore derives. With the discovery of the New World, it was recognized that the native Americans practiced an herbalism in which the relationship between people and plants was deeply rooted in spiritual concerns. In America during the early nineteenth century, European and Native American herbology combined into an eclectic naturopathy which was widely utilized by lay practitioners (Bliss, 1985).

Following the Civil War and the laboratory synthesis of morphine, professional medicine began its dependence upon advanced technology, particularly laboratory produced chemical drugs. This practice is standard operating procedure in the medical community today, although some inroads have been made in light of the newly awakened interest in holistic health and the new herbalism (Nebelkopf, 1979).

There are herbs which can replicate the effects of most commonly used psychoactive drugs. Herbal "uppers" include guarana seeds, cola nuts and yerba matte, which, like coffee, contain high concentrations of caffeine and act as potent herbal stimulants. On the other hand, there are herbal stimulants which do not contain caffeine (e.g. ginseng, gotu kola, sassafras, sarsaparilla), but which do have definite stimulant effects on the nervous and circulatory systems without the negative effects of coffee.

In addition, there are herbal "downers" which include valerian root, hops, skullcap and chamomile. Valerian root is a very powerful herbal tranquilizer and nerve tonic. Hops are a major ingredient in beer and are relaxing in their effects. Chamomile is an old-fashioned home remedy for cranky children when made into an herbal tea. Relaxo Brew, is a non-addicting relaxing tea helpful in cases of insomnia. This blend consists of valerian root, chamomile and spearmint.

Herbs have proven effective in aiding detoxification from drugs like methadone and heroin. From a holistic point of view, the "getting sick" which an addict experiences during withdrawal is actually the first step in the process of healing. The symptoms of detoxification reflect the active changes the body is going through in order to find healthier balance. Opiates depress the respiratory system and heroin addicts report that they don't normally get colds while they are strung out on opiates. However, once the addict begins the process of detoxification, all of the symptoms which have been suppressed for so long by the opiates begin with exaggerated effect until the bodily systems achieve a new balance. The emergence of such symptoms as colds, runny nose and diarrhea dramatically point out that healing is taking place (Nebelkopf, 1981).

There has been some success in using herbal teas to combat the symptoms of detoxification and to promote healing. Detox Brew is an herbal tea blend consisting of comfrey, mullein, spearmint, rose hips, orange peel and golden seal. It acts as a tonic for the respiratory system for addicts who are detoxifying from methadone or heroin. Comfrey and mullein are old folk remedies for respiratory disturbances. Golden seal is a tonic for the liver and kidneys in helping to eliminate toxins from the bloodstream. Rose hips and orange peel are high in vitamin C, which is helpful in detoxification. Spearmint is mildly relaxing and has a pleasant sweet taste.

The ways in which humans relate to plants and herbs is just beginning to be understood. Drug addicts/users may be said to assign "magical powers" to their favorite herbs on an unconscious level. The heroin addict may "worship" the opium poppy. The cocaine addict is enamored of the seductive coca queen and the wino is hooked on sour grapes. It appears that most substance abusers are hooked into a belief system regarding the powerful effects of plants on the human organism. These beliefs can be transmuted into a positive force if they are expanded to include plants that can facilitate health. By choosing such plants as comfrey, golden seal, mullein, ginseng and valerian root, the substance abuser can begin to explore a healthier and more natural lifestyle.

In a holistic approach to substance detoxification and rehabilitation, nutrition plays a vital role (Sorensen & Acampora, 1984). Drug addicts/users and alcoholics are notorious for their poor diets, and drugs such as heroin, tobacco, coffee and alcohol deplete the body's store of essential vitamins and minerals. Drugs may produce dietary deficiencies by destroying nutrients, preventing their absorption and increasing their excretion.

In working with drug addicts on improving their diet, it is important to be flexible, non-moralistic and to emphasize a wide variety of wholesome, unrefined and unprocessed foods. White sugar, white flour, excess salt and greasy fried foods should be slowly and gradually eliminated from the diet.

Nutrition is an area conducive to many trends and fads. Probably the most important aspect in helping to change the diet of substance abusers is to avoid rigidity. Simplicity is also important. Small changes in the direction toward a more natural and wholesome diet should be reinforced. In this way substance abusers can learn to listen to their own bodies in terms of their own nutrition needs (Land, 1983).

The therapeutic community emphasizes a drug free lifestyle. The focus is on developing responsibility, discipline, emotional honesty and the appropriate expression of feelings. Unfortunately, most therapeutic communities ignore nutritional factors in their approach. Although there is a strong negative emphasis on drugs such as heroin, alcohol and marijuana, there is considerable abuse of "softer" drugs like coffee, sugar and tobacco.

Since residents of therapeutic communities eat three meals a day in a residential setting, it would seem relatively easy to incorporate principles of good nutrition in these programs. However, food service systems in residential programs usually provide "institutional" foods, high in starches and sugar. A move toward utilizing whole unprocessed foods, herbs and vitamins in therapeutic settings would definitely improve the services rendered.

Changing the dietary patterns in TC's is not easy. This is due to a lack of awareness and inertia. Many TC's are so crisis-oriented that prevention through proper nutrition is a very distant concept. In an experiment at Walden House, natural foods were prepared and the residents' responses were tape-recorded (Nebelkopf, 1978). It was interesting to note that many residents contacted their positive feelings concerning institutional foods. There were many residents who had never eaten three regular meals a day. Such natural foods as toffee and seaweed were received with very negative reactions by the majority of residents. There was, although, a small but vocal minority who expressed very positive feelings toward natural foods. By and large the residents felt that their diet could be improved and that this could enhance their health. What was learned from this experiment was that a move toward natural foods should be slow and simple. There was universal interest in having fresh salads and fruit available, and that brown rice should be substituted for white rice if it was cooked properly.

The training of substance abuse counselors in the principles and practices of alternative health can help them to be more effective with their clients, and can diminish the sense of hopelessness and burnout in the field. The use of herbs, nutrition, bodywork, acupuncture and biofeedback are available and relevant alternatives in the field of substance abuse treatment. The incorporation of these methods geared toward actualizing the whole person in the TC is an important new direction for the eighties.

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NUTRITION AND DIETARY CONCERNS IN THE TC

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Optimum nutrition can improve the effectiveness of staff members and the recovery of residents in a therapeutic community. Contemporary approaches to nutrition, however, must emphasize its effect on brain function, addiction and behavior.

Nutritional approaches to the prevention and treatment of addiction and behavioral problems are becoming increasingly popular but, with few exceptions, have not been taken seriously, or incorporated substantially into treatment by therapeutic communities. These behavioral problems include delinquency, anti-social behavior, learning difficulties, alcoholism and drug addiction.

A healthful approach to treatment is based on a model that empha- sizes:

- developing overall wellness (nutrition, exercise, stress management, relaxation techniques, spiritual health) with diet and nutrition as the central focus;
- dietary and nutritional variables in brain and central nervous system function;
- how poor nutrition can lead to and sustain chemical dependency;
- how wellness and optimum nutrition can increase the success of treatment programs by supporting existing treatment methods; and
- the cost effectiveness of wellness programs.

Contemporary views of addiction are based on a broad formula:

ADDICTION = GENETICS + ENVIRONMENT

- Of these two factors, genetics is essentially fixed but environment is controllable to varying degrees.
- Control of environment means control over, or development of wellness skills.
- A focal point of wellness is nutrition.
- Successful incorporation of nutrition information must be done within a systems or holistic framework. The major interlinking concerns or components in this framework include:

    Diet
    Therapeutic supplements
    Blood sugar and substance abuse
    Food allergy/addiction and substance abuse
    Candida (systemic yeast infection) and substance abuse
    Overall wellness skills
    Staff, resident, outpatient and family training
    Organizational (T.C.) structures that support rather than inhibit wellness

Overall Wellness

The wellness concept of alcoholism or chemical dependency is based on:

- Empowering as well as "fixing" a recovering person
- Operating from a wellness rather than a disease perspective in addition to simply treating the illness
- Envisioning a healthy future -- visualizing oneself as healthy in addition to simply treating the illness
- A focus on optimum rather than simply adequate nutrition

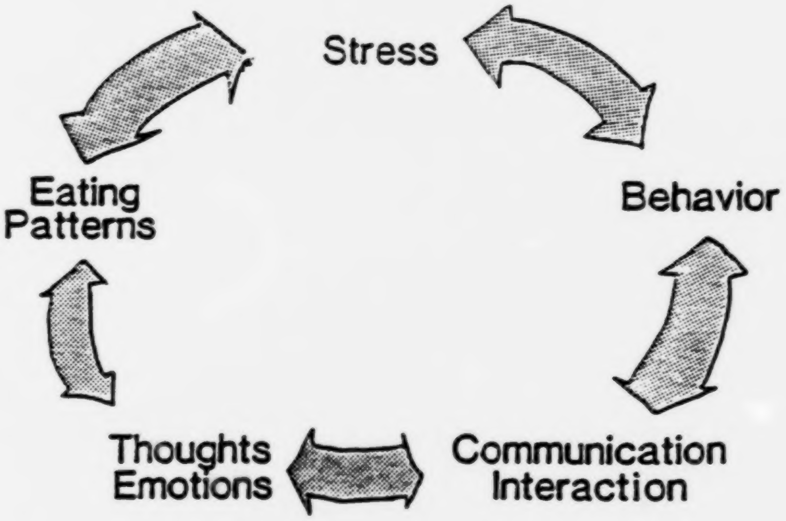
HOLISTIC APPROACHES

Stress Exercise

Nutrition

Relaxation Spirituality

- Whole Food ⟹ Whole Person
- Psychological Balance
- Whole vs Processed Food
- Therapeutic Nutrients



Stress

Behavior

Communication Interaction

Thoughts Emotions

Eating Patterns

Overall wellness consists of many interlinking activities or practices. Wellness skills are based on what one can do as opposed to what is done to someone.

High Level Recovery means recovery at a level that is optimum -- doing the best that is possible. It means minimizing relapse, depression, physical, mental and emotional dysfunction, and other characteristics of poor or unsuccessful recovery. The difference between various high and low levels of recovery is wellness in general, and optimum nutrition in particular.

Diet and Nutrition in Brain and Central Nervous System Function

Psychonutrition focuses on the link between nutrition and brain function. As a result of this link, poor nutrition can contribute to various physical, mental and emotional symptoms that often lead to and sustain substance abuse. Nutritional imbalance can contribute directly or indirectly to substance abuse, pain, general deterioration and dysfunctional behavior.

On the other hand, optimum nutrition can be the basis of high- level recovery, relapse prevention, prevention of high-risk health conditions and the creation of Wellness and Health Oriented Learning Environments (WHOLE).

While traditional approaches to nutrition are often simplistic, inadequate, and definitely not exciting or empowering, holistic approaches emphasize:

- The importance of whole food (not just vitamins, minerals and processed food) on the whole person
- The link between nutrition and "psychological" problems
- The use of nutrients vs. therapeutic supplements

Poor Nutrition Can Lead to Substance Abuse

Links exist between eating patterns and various aspects of individual performance or functioning: stress, eating patterns, thoughts and emotions, communication/interaction and behavior can interact, both positively and negatively, with every other element.

Some ways of thinking about nutrition and its relationship to addiction and behavior include:

- The question of what relationship one has with a drug, a food or other substance. Optimum nutrition can contribute to a "healthy" (i.e. non-abusive or non-addictive) relationship -- poor nutrition can contribute to the opposite condition.
- The question of whether poor nutrition is related to limited intake of nutrients or to limited ability to utilize nutrients
- The theory that some people are addicted to foods used to mimic their preferred alcoholic beverage.
- The link between nutrition and personality, self-management and coping skills.

Contemporary, holistic concepts are based on several key questions:

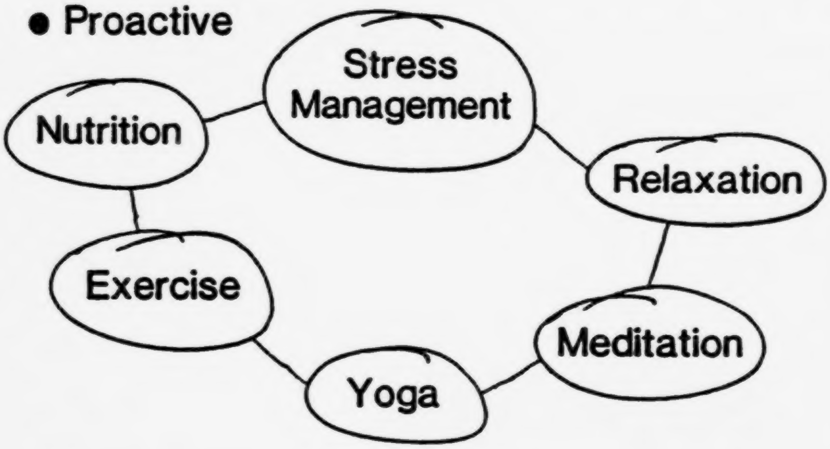
- In what way does food allergy/addiction contribute to substance abuse?
- How are eating disorders related to drinking disorders and drug use?
- How does one's biochemical individuality or uniqueness create unique needs for food or nutrients?
- In what way do blood sugar ups and downs contribute to the urge to drink or use drugs?
- How does poor nutrition contribute to psychosocial problems that increase one's risk for abuse or addiction?

NUTRITION FOR OPTIMUM RECOVERY

- Control Hypoglycemia
- Identify Food Sensitivities
- Therapeutic Supplements
- Whole Foods
- Centered Diet
- A Transition Plan

WELLNESS

- More Than NOT Being Sick
- Proactive



Stress Management

Nutrition

Relaxation

Exercise

Meditation

Yoga

Optimum Nutrition Can Increase the Success of Treatment

Nutritional therapy focuses on:

- Content -- what foods or supplements support recovery
- Process -- values, priorities, routines, relationships and other potential issues involved in to designing and following a food and nutrition program that supports recovery

Therapeutic approaches include the following content issues or questions:

- Can therapeutic doses of certain nutrients eliminate extreme deficiencies (or dependencies) and thereby enhance recovery?
- Can a diet for unstable blood sugar be helpful?
- Is there evidence of food allergy or sensitivity?
- Is there evidence of systemic Candida infection?
- Can amino acids, essential fatty acids (therapeutic oils) or other special supplements enhance recovery?

An optimum plan includes the following: control of hypolgycemia, identification of food sensitivities, therapeutic supplements, whole foods, a centered diet and a transition plan.

Here is a diet that will increase one's risk for substance abuse and dysfunctional behavior:

- 45% fat
- 20% refined sugar
- 12% protein (from 70% animal sources)
- 18% carbohydrates (60% processed)
- 130 pounds of sugar per year (40 teaspoons per day)
- 250 pounds of meat per year (3/4 pound per day)
- 1/3 pound of fat per day

As you might know, it's the Standard American Diet (SAD); it's what the average American consumes. About half of us do worse (i.e., higher risk). Consumption of refined sugar is a major health problem. It is well known that it is a contributor to diabetes, tooth decay, and obesity. But refined sugar also creates impairment in other areas: sensitivity to pain, insomnia, moodiness, fight bacteria, energy, focus.

Most of us "balance" our diets by eating from both extremes:

- Eating a lot from one extreme (salt and animal foods) creates short- and long-term cravings for "foods" on the other extreme (sugar, ale, caffeine, drugs) and vice versa.
- A healthy diet is both balanced and centered, i.e., 80% from the middle of the see-saw and 20% from the extreme ends.
- The Standard American Diet (SAD) is the opposite.

A centered and balanced diet can decrease one's risk for substance abuse, make a major contribution to recovery and to physical, mental and emotional balance and centering.

RUN FOR RECOVERY: AN INSIDER'S VIEW

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For me, this race started two months ago. The first part involved the race to get in shape, and to get other physical needs met. I needed running shoes and clothes, a special diet, vitamins, and permission to train every day. I could not have done all of this without the support of the family, the staff members, and the other runners.

There are many people I would like to thank: Food Services, who helped the runners with our dietary needs, the various individuals who covered me on my job function so that I could train, the family members who did the house G.I.'s on weekends while I trained, John Rios, who was behind this run 110%, and Nick Nelson, who made sure that training time was available on weekends.

I must also commend the other runners for their high degree of commitment. Excluding one unexpected injury and one person who left while the house was on containment, we had only one person drop out of the running team. Everyone else trained hard, and finished the race. A high degree of commitment indeed!

On Sunday morning, I woke up early, and when I looked out of my bedroom window, I was greeted by a perfect day. I knew that this would be a challenging race for me, and that I would have to watch my pace. I had a light breakfast, in the hope that it would make a difference, and also found that I had a hard time keeping away from cigarettes. I was feeling some pre-race anxiety.

The runners from Walden House decided to walk to the Polo Fields, in order to warm up our legs. I also noticed pre-race anxiety in my comrades. As we walked along, there was a lot of laughing, joking and kidding. It seemed like a good act-as-if to me, to cover the anxiety among us.

When I arrived at the Polo Fields, there was some discretion as to what the actual course would be, since it had changed and was different from the map sent to me. But I was assured by an official that the course would be well marked and monitored, and with that issue out of the way, I went to the starting line to warm up.

There were approximately three hundred runners at the starting line, but in my mind there appeared to be more. I made a decision to start at a slow pace, as this was to be my first 10k race, and I was here for the experience. Any chances of winning was already out of my mind.

When the starting gun sounded, I took off. I started at a slow pace, but found it difficult not to run faster, as many people were passing me.

Although I didn't like being passed by other runners, I knew that a faster pace would eventually take its toll, so I kept to a moderate pace. At the first turn, I heard a familiar sound, the combination of running shoes slapping pavement, and air rushing through mouth and nostrils. When I looked over my shoulder, there was Jack H. coming on strong.

When he came alongside me, I said to him," Slow it down a bit, Jack, when they hit the hill, they'll be dropping like flies." I ran with him briefly, but his pace was too fast for me, so I let up and ran at my pace. At the second turn I greeted Paul C. who was monitoring, and I turned right and headed east on Kennedy Drive. I was feeling good at that point, having warmed up properly before the race, and as I passed the one mile marker, I saw my girlfriend, Sandy, who was there to cheer me on. I wanted to stop and talk to her, but I fought the impulse and continued on.

And then came the hill. Now, I have to tell us this: when driving east from the back on Kennedy Drive, between Lakes Drive and Traverse Drive, or when walking that same segment, it doesn't appear to be much of a hill, it doesn't look like a hill at all, a gentle rise maybe. But try running that distance, fast, or slow. At any speed above a walk, that gentle rise turns into a hill. So I slowed down, controlled my breathing, and I made it! And somewhere between there and the three mile marker, I passed Jack H. I was going down hill now, so I picked up my pace. I passed the start line, and was back at the first turn again, then the second turn and then back up Kennedy Drive. But this time it was different. After four miles, any physical reserve I had was already spent. My left foot was slowly going numb, and I was finding it very difficult to breath. So I slowed down, and then I had to slow down some more. I don't remember where Jack H. passed me, but I remember where George R. passed me. It was at Lindsley Meadows, and when he passed me, I felt demoralized and humble. I knew that I was faster than George but I had underestimated his endur-ance and overestimated my own. And I was also feeling embarrassed. It was a blow to my ego when George passed me. Real clinical stuff!

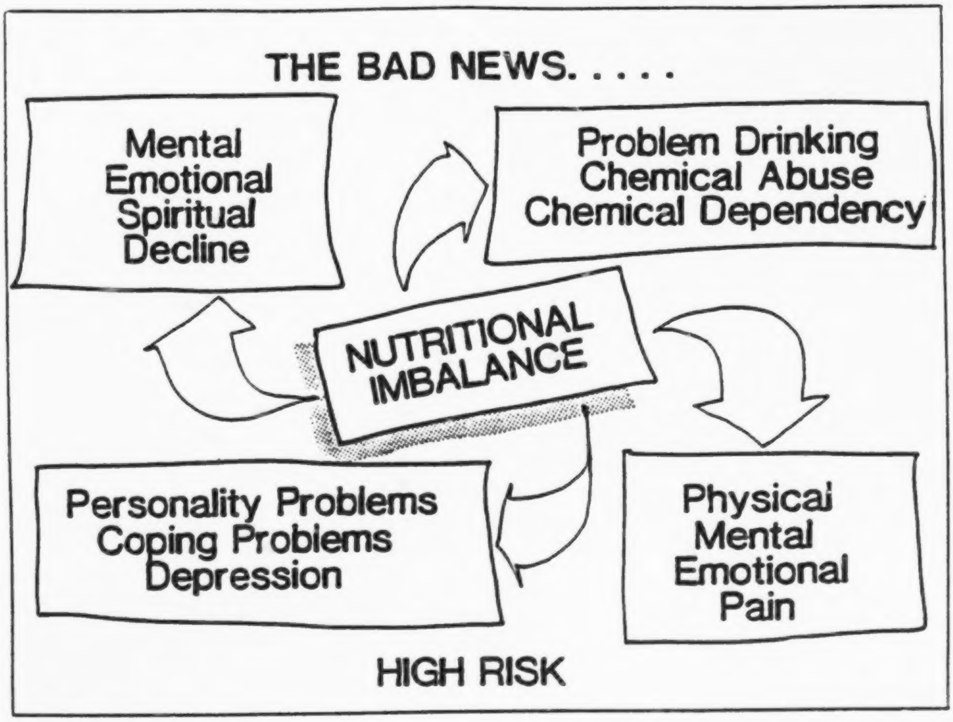
So shortly after he passed me, I stopped running, and walked for a minute to catch my breath. I started again, and had to stop one more time, and when I continued again, at a slow pace, I regained my composure and my ability to finish the race. I turned on Traverse Drive, and turned again on Middle Drive, where I found it easy to pick up my pace again, until I found a comfortable stride. I made it to the finish line at that speed, and received a spiritual boost when I heard the cheers of the Walden House family as I crossed that last marker.

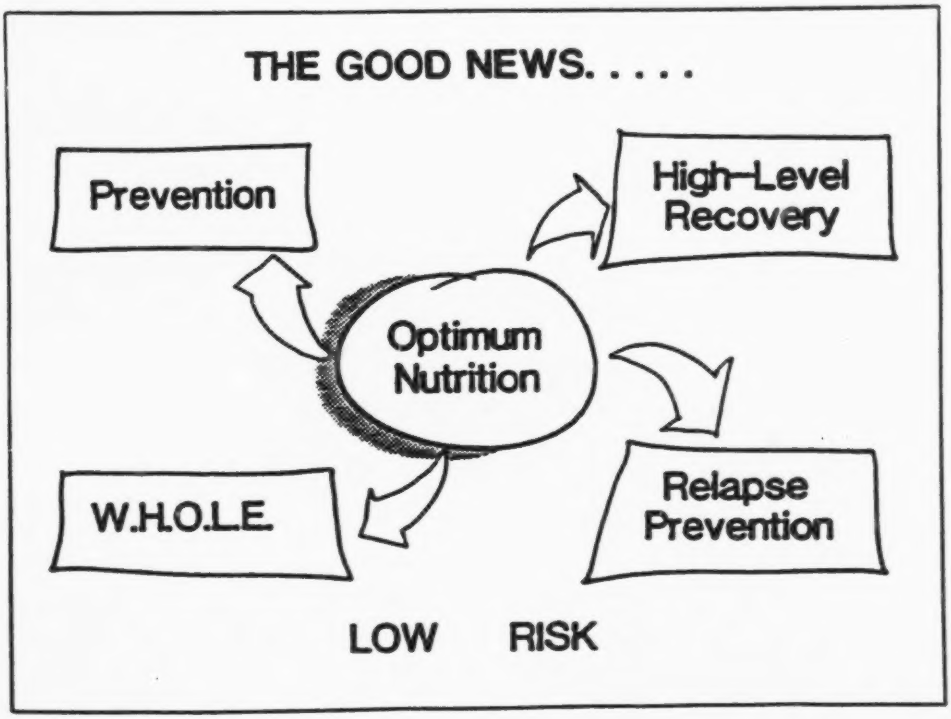
The satisfaction and joy I felt soon turned into concern, when I came upon a group of people standing around Charlie T., who was on the ground.

Charlie had apparently put out all that he had, and collapsed after crossing the finish line. He was semi-conscious for ten to fifteen minutes. It hurt me to see him in that condition. He slowly regained consciousness, and under advisement from the paramedic on hand, he was sent to a hospital far a complete check up.

When the awards were given out, Elizabeth S. received a gold medal for first place in the Womans' Recovery Division. George R. won a dinner for four in the raffle.

My reward was the personal satisfaction I felt, and the encouragement I received from my teammates and friends. I also feel that the high degree of commitment by the runners, and the high degree of support from the family and staff will set a standard for all who will follow us in the future.


THE BAD NEWS. . . . .
Mental Emotional Spiritual Decline
Problem Drinking Chemical Abuse Chemical Dependency
NUTRITIONAL IMBALANCE
Personality Problems Coping Problems Depression
Physical Mental Emotional Pain
HIGH RISK


THE GOOD NEWS. . . . .
Prevention
High-Level Recovery
Optimum Nutrition
W.H.O.L.E.
Relapse Prevention
LOW RISK

CHAPTER 5

MENTAL HEALTH AND THE TC

PSYCHIATRY & THE TC

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I can't recall a time when I wrote a speech for someone else to present. I have difficulty imagining how these words will sound coming from someone else's lips. If, at times, the words sound overly sentimental - forgive the speaker; it is the writer who has stepped over the bounds of formality to speak to old friends and to express regret at missing an opportunity to meet the new generation of leaders in the world of T.C.s.

I wanted very much to be with you at this meeting, because there were so many old friendships that I wanted to renew and so many faces that I wanted to see again. I knew that there would be at this meeting old comrades from the early battles to establish the validity of the T.C. as an effective intervention, not only for problems of addiction, but also for problems of character and behavior unrelated to drug abuse. I have many vivid memories of those early struggles, and I must admit they grow fonder with the years.

It has been more then 20 years since I first visited Synanon and Daytop Village and became aware of a remarkable and innovative concept that was certain to have an profound impact not only on the treatment of addiction, but on the fields of psychiatry, criminal justice, and sociology, as well. At the time, I was a junior faculty member in psychiatry at a medical school in New York. Unlike some of you who have grown up with the therapeutic community movement, I have had a number of very different roles over the intervening twenty years. They have at various times involved research and teaching at medical schools, consulting with government and private industry, and developing and running programs related to drug addiction at both State and National levels. From time to time, some of the titles of the positions were far more impressive than I would have wanted. I have never felt comfortable with titles and formality. Perhaps that is why I felt at home in therapeutic communities where, in the early days, you knew that last week's new entry could be next year's facility director. The quality resided in the person, not in the credentials or the title. Today, I am temporarily wearing one of those formal hats again: Acting Director of the National Institute on Drug Abuse. I hope that you will not let your image of that role color what I plan to say here - for I do not speak so much as the Acting Director of NIDA, but as a long time observer of the field and as a long term friend of the therapeutic community concept.

I want to speak of old friendships, old tensions, and new challenges.

OLD FRIENDSHIPS - because it is only upon trust and human relation ships that individual organizations can thrive, and only when there are such relationships that different organizations can work together effectively.

OLD TENSIONS - because the therapeutic communities grew up in an atmosphere when they were often looked upon with skepticism by researchers and mental health professionals, and in which they, in turn, went to great lengths to criticize and often to exclude or minimize the contributions that such professionals and a research orientation could make.

NEW CHALLENGES - because we must recognize that new findings about the co-existence of addictions and other forms of mental illness cannot be forever ignored and because a deadly new virus - the AIDS virus - has emerged and is spreading rapidly among the drug abusers that the therapeutic communities were created to help.

OLD FRIENDSHIPS: Some of my fondest memories of the past 20 years are of the times I spent at Gateway House in Chicago. It wasn't always known as Gateway - but that is a story for another time. Had Synanon been more willing to establish a facility in Chicago, Gateway might never have come into existence. Nor was Daytop Village at the time, 1967, ready to open a facility that far from its home base. But in 1966, when the planning for treatment programs in Illinois began, I felt that a therapeutic community had to be part of that plan. Daytop was a key element in the establishment of Gateway. Patients I saw in Chicago in 1967 were sent to Daytop in New York with the hope that they could learn enough to develop a facility in

Illinois when they returned. (Some of those patients have since gone on to graduate from professional schools and to enter government at high levels.)

I remember, too, the problems we had in finding the resources and the location for such a facility. Neighbors were wary; use of a house as a Therapeutic Community violated zoning laws. The State of Illinois would not let its funds be used to purchase real estate, and no one would give a mortgage to the fledgling Gateway House Foundation which had no assets and no income. At one point, I became personally liable for the mortgage on one of Gateway's early facilities, much to the dismay of my family, who had images of bank foreclosures and furniture on sidewalks.

But, the return on the investment was greater than any I have made. While I lost some money, I got to know the people who made the system work. My children, my wife, Faith, and I felt at home at Gateway; Gateway even adopted our kittens.

By that time, there had been a change in the organizational structure at Daytop in New York. Key staff members left the organization, just at a time when Illinois was expanding its commitment to treatment, including therapeutic community. We were lucky. David Deitch, Carl Charnett, Michael D'Arcy, Ellen Afterman, Jeanne Peake, Mickey McCallup, and several others were willing to come to Illinois to teach others and to help build the system. Those were days filled with the excitement of a new enterprise. They were also days in which the rivalry between T.C.s and other treatment methodologies that seemed so strident and bitter on the East Coast were far less apparent in Illinois. Instead, there was a willingness to see a role for a range of treatment efforts and for a range of skills including those of physicians, psychologists, and psychiatrists. Early in Gateway's history, a resident psychiatrist I was supervising spent part of his elective time living at the facility.

Fortunately for me, my close friendships with leaders of any one therapeutic community have never interfered (as far as I could tell) with my associations with many of the other pioneers in this field - Monsignor O'Brien, Dan Casriel, Mitch Rosenthal, George DeLeon, Judianne Densen-Gerber - to name only a few. Most have forgiven me for continuing to see a useful role for pharmacological approaches to treatment.

OLD TENSIONS:- The antiprofessionalism - especially the anti- psychiatry bias - of the early years may already be part of the past. If it is, there is no need to dwell on that part of the past. If such feeling persist, however, it will become increasingly necessary to address them, for the challenges to the Therapeutic Communities, at least as I see them, are three-fold:

First: How to deal with a health-care system that is increasingly concerned with costs and is focusing ever more closely on the mental health, drug, and alcohol in-patient sector as an area where savings can be achieved. Second: how to deal with one of the major research findings of the past decade - that most drug abusers have experienced substantial degrees of psychopathology in addition to their problems with drugs and alcohol, and that the severity of these problems has a major influence on how they respond to treatment. Third: How to deal with AIDS.

I will not deal the first; I promised to discuss the second; and I feel obliged to touch upon the third.

The notion that those who become dependent on drugs have other psychiatric; problems is not new. Lawrence Kolb, who studied morphine and heroin addicts in the 1920, clearly described the many psychiatry problems he found. It was not the assertion that additional problems were present that created difficulties between general psychiatry and those who specialized in problems of addition. What usually caused to difficulties was that many in the mental health field were used to looking for the "underlying problem." They leaped too quickly to the view that if only they could treat successfully the "underlying" depression, anxiety, rage, neurosis, or what have you, the drug problem which was assumed to be a symptom of that underlying disorder would go away on its own. For the most part, those mental health professionals who dealt with drug users on the basis of this assumption were not successful. Too often, their lack of success did little to persuade them to re-examine the assumption. Too often, they assumed that what was needed was merely more psychotherapy or psychotherapy under conditions of confinement, involuntary, if need be.

In contrast, when the therapeutic communities emerged and demonstrated, as had AA before them, that drug and alcohol problems could be treated and often "cured" without dealing with any concerns about underlying psychopathology, seeds were sown that grew into a disregard for both the presence and the significance of any co- existing mental problems. This disregard was given further momentum by some of those who advocated the use of methadone maintenance. Observing what they considered to be dramatic decreases in antisocial behavior and increased productive behavior in their early patients, they concluded that most, if not all, of the character problems attributed to addicts were a result of their addiction, not the cause of it. Furthermore, they believed that once the addiction was controlled, the addicts would require jobs and rehabilitation, but not necessarily psychiatric or psychological help, to become productive citizens.

For about five years, there was no significant challenge to these views. The depression known to be prevalent among drug users and the high suicide rate were generally attributed to the consequences of drug use and drug-using life style. Then things began to change. Researchers, first those working with patients in methadone programs, began to report that symptoms of depression were far more common than among the general population, and that while many patients improved after entering treatment, others did not and some got worse. Further, some developed alcoholism that was not previously prominent. Over the course of a few years, these observations were repeatedly confirmed. Then there was a further development - a technological innovation. Psychiatrists became more objective and more precise in the way they used psychiatric terms and diagnosed psychiatric disorders. They began to use specific criteria, instead of leaving the diagnosis to each practictioner who matched the patients symptoms against his or her impression of what constituted a particular illness. These diagnostic criteria evolved into a revised diagnostic manual for the field, more popularly know as DSM-III. This manual contains diagnostic criteria for a wide range of psychiatric disorders, from schizophrenia to phobia, and from depression to anti-social personality.

When the criteria were used and applied to interviews with drug users entering treatment in a number of different types of programs, it became apparent that it was rare to find drug dependence without some other accompanying syndrome or personality disorder.

One distinction needs emphasis. Not everyone who has ever been depressed is depressed all the time. Therefore, for some illnesses, such as depression, panic disorder, phobia, and schizophrenia, there is a distinction between lifetime prevalence - (how many patients have ever had a disorder), and current prevalence - (how many have the disorder at the time of interview).

Lifetime prevalence is always higher than current prevalence. Note how common some of these disorders are. For example, the lifetime prevalence of any affective or mood disorder is almost sixty percent. Only a minority of addicts entering treatment are free of all diagnosable psychiatric disorders apart from drug dependence.

What is not shown is that multiple diagnoses are not only possible, but common. Thus, drug abuse, alcoholism, depression, and antisocial personality frequently coexist.

The same general pattern of coexistence of drug dependence and psychiatric disorders was seen among a Veterans' population by the research group in Philadelphia headed by O'Brien, McClellan, Woody and coworkers. More importantly, the group has found that the severity of psychiatric difficulties is the single most powerful predictor of outcome across a range of treatment programs, including therapeutic communities. Those with minimal severity of symptoms tended to do well in all programs; those who had most severe problems tended to do poorly no matter what program they entered.

The Philadelphia group also developed a scale, called the Addiction Severity Index, which measured the severity of a number of problems, including legal, family, work, as well as mental health. Overall, Severity scores on this questionnaire, which is rather easy to use, also predict outcome across the range of treatment programs.

This research group also has shown - (and their careful work has generated both attention and controversy) - that within the context of a methadone program, psychotherapy can improve the bleak outlook for those who have the most severe psychiatric problems. I want to emphasize that the work did not directly compare drug counseling to psychotherapy; it compared psychotherapy plus counseling to counseling alone.

Beyond this one finding, it is not clear just how to respond to the now repeatedly confirmed finding of psychopathology among treated drug abusers.

Depression is common among drug users entering all types of programs, including T.C.s. In a large percentage of patients, the depression gets better on its own, but about 20 to 30% remain symptomatic. Some researchers have tried various antidepressants, but thus far the results are disappointing.

At present, no one can say whether psychotherapy is the only way to improve the outlook for those with severe psychopathology in methadone programs, or whether indeed the findings from the Philadelphia group hold for more traditional T.C.s that do not primarily serve veterans; nor can we even say whether all types of psychiatric disorders imply an equally reduced outlook for success in treatment, or whether they effect equally the likelihood of relapse.

In short - you've heard this before, - more research is needed. What is not likely to go away is the fact that most drug abusers have Psychiatric or emotional problems apart from their drug dependence. Should Therapeutic Communities be asking whether such diagnoses or their severity affect the likelihood of doing well? I think that they should. I think that there may come a time, as Therapeutic Communities adopt more procedures used in traditional health care facilities in order to get more regular financial support, that they may be expected to consider such factors - if not be government agencies or third party payors, then eventually by the lawyers who undoubtedly will discover that T.C.s, like doctors, hospitals, and other treatment facilities, can be sued.

I want to turn now, only briefly, to the subject of Acquired Immune Deficiency Syndrome, or AIDS. In my view, the emergence of this fatal viral illness will have a more profound adverse effect on the lives of drug users and those of us who work with drug dependent patients than any single development in our lifetime.

The AIDS syndrome was first described among homosexual men in 1981. It was then noted to be prevalent among IV drug abusers as well. It was suspected early that the syndrome was caused by a virus that can be transmitted from one person to another. That suspicion has been confirmed and a specific virus, called Human T-cell leukotrophic virus type III, or HTLV-III has been isolated. The virus is found in a number of body fluids, - blood, semen, saliva, and tears, - and can be transmitted by intimate sexual contact, by receiving infected blood, or by sharing needles with someone who has the virus. Official statistics which indicate that AIDS is primarily a problem of homosexual men underestimate the significance of IV drug use. Further, in some parts of the country, 50% of AIDS cases are found among IV drug users.

Thus far, 3,000 IV drug users have died of AIDS. It is estimated that an additional 50 to 100 thousand individuals have been exposed to the virus - anywhere from 25% to 50% of these are IV drug users; 10% of those exposed will probably die over the next year.

How will the Therapeutic Communities handle an active case of AIDS? Should all applicants be screened for AIDS virus? Should those who are positive be excluded, segregated, or isolated? Do we need special Therapeutic Communities for those with AIDS? I may be wrong, but I suspect that those who develop AIDS may lose most of their motivation to undertake a major change in lifestyle. But that might be a mistake. It may be that it is repeated exposure that overcomes the body's resistance. In any event, when a T.C. operates like a family, it will be hard to force out a family member who develops a serious illness, no matter how frightening.

No one can predict what the future of the AIDS epidemic will be. I can tell you this, however. Over the past four months, no issue has been given higher priority at NIDA than AIDS. NIDA plans to do far more to tell workers in the field what we know about AIDS and what they can do to reduce the spread of the disease, to ease the troubles of those who have it and to safeguard those who don't. We would like to use the new blood test to find those exposed to the virus but not yet exhibiting the syndrome. We want to know what influence drug use has on further weakening resistance to the virus. We want to know what kinds of messages and appeals motivate those with AIDS to reduce the kinds of contact that give it to others. In short, since we have as yet no treatment and no cure, our only hope lies in finding ways to slow its spread.

NIDA no longer has the responsibility or the resources to fund a frontal attack on this new threat. But we do have responsibility to fund research that will be useful to all of you on the battle lines. We will try within the limits of our resources to meet that responsibility, but NIDA has no special expertise in knowing what messages or techniques work. We need your ideas. We need the old partnership to work again.

It may be necessary to fight the battle on two fronts: one against AIDS among those we wish to help; another to convince the larger society that unless they provide timely support, the epidemic may spill over form the drug using population and the homosexual community to the general population.

It is said that friendships formed in the foxhole last a lifetime. Together, we have been in battle before. Let us go into the new battle, together again.

THE CHEMICAL BRAIN

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Los Angeles, California

As you see from the program, I was supposed to speak here for a few minutes on the chemical brain and if it may seem obscure to you why people in a therapeutic community should be exposed to such a talk, I offer as a background from what is going on in the micro universe of the skull within the skull to what you're doing in the macro universe of real humans and groups of humans.

There are analogies between the chemical processes that are being uncovered that go on in the head with those impacts that you deal with -- emotional, cognitive, perceptual -- in the world that you practice in. Both affect each system. Each affects each other. There is feedback from an experience in a therapeutic community to the microprocessing of chemicals that goes on in the head and visa versa. So you should know a little bit a these exciting developments that are going on regarding chemicals in the brain.

At one time, perhaps 50 years ago, the brain was considered like a piece of Jello. There was just a lot of goopy stuff without even thinking of specificity. We now know that this is completely untrue, that there are specific areas with specific activities, and that each area or group of areas has a chemical specificity. Many transmitters, neurotransmitters, have been uncovered over the past 15 years, and we have obtained significant new knowledge about the chemistry of the brain.

These neurotransmitters do important things. The nerve cells of the brain transmit their signals electrically until they get to the end of the nerve cell or where it hooks up with another nerve cell at the synapse. At that point, the transmission becomes chemical and the chemistry of the brain causes either an enhancement or a subtraction of the signal. The synapse is a control point which has developed somehow so that it can say "Go" and produce an effect or "No, don't go" and inhibit the effect. It is enormously complex -- so complex that I couldn't possibly explain it in the time I have here even if I could explain it.

All our psychotherapeutic drugs are based on moderating what is happening at this interface between nerve cells at the synapse. A class of chemicals has been discovered called endorphins and encephalons. These are the internal narcotics, if you will. They don't look like morphine or any of the narcotics that are external to the body, but they are received in places in the brain called receptor sites, which are identical with those places where opiates are received and produce very similar or identical effects. Relief of pain is the one we think of immediately, but also they have enormous potential, apparently, for changing emotionality.

I do want to specifically talk about one such neurotransmitter as an example of what goes on in the head. I want to say something about the dopamine system. Dopamine is an important neurotransmitter in many parts of the brain. In fact, the disease we call schizophrenia is supposed to be due to increased dopamine activity in certain specific parts of the mid-brain. And, as you might expect, the treatments, the drug treatments of schizophrenia -- so called antipsychotic drugs like Thorazine, Haldol, and so forth -- have many actions, but their important action is that they inhibit or they block the dopamine receptor points causing this surge of dopamine that clinically we call schizophrenia to be to be reduced so that a few schizophrenics can really be called cured if they are given these drugs early enough. For chronic schizophrenics -- the story is different.

So that is one part of the dopamine story, but there are many others. Consider our present concern with cocaine, for example. How does cocaine act in the brain? It appears that what cocaine does is to stimulate the reinforcing centers or pleasure centers of the brain. Cocaine blocks dopamine from being transmitted at the synapse and causes a surge of elation, high, ecstasy, whatever you want to call it, that is associated with the use of cocaine, especially with the intravenous use of cocaine. This is the immediate, powerful, positive emotional state that causes it to be so attracting to so many people over time. So by the allegedly simple action of not allowing the dopamine to be drawn back into the cells from which is was discharged or fired, the dopamine causes a brief but very impressive stimulation of the reward centers of the brain.

How can we deal with such a situation? Well, we can deal with it on a chemical or non-chemical basis. On a chemical basis one can think of blockading that area of the dopamine receptors. This has been tried with anti-depressants. We could think of using a dopamine stimulator which does not cause euphoria and this has been experimented with briefly. We can think of somehow reducing availability of cocaine, and there are no good thoughts that I know of in this regard. But as you are developing your tricks and techniques, so also are the chemists trying to develop theirs to somehow help in dealing with the problem of cocaine.

And I might say that in all respects amphetamines do very similar things as cocaine. Just why cocaine is so popular at the moment and amphetamines not so popular I am not sure, especially when they are both used intravenously. The only difference seems to be that the amphetamine glow lasts longer. Otherwise, descriptively, these are very similar chemicals acting very similarly, interacting with the dopamine system, as I have suggested.

Well, this is a small piece of a great story, and I think it's necessary for you to be aware of what is going on in the world of the microscope, of molecular chemistry, and I have given you a little bit of a background on this amazing organ we have inside of our skulls. What surprises me as much as anything is the fact that we have this enormously almost indescribable instrument up there and yet so many of us try to alter it with substances of dubious purity and unknown quality. The brain is a very precious instrument. I think you would agree with me from your perspective. But as one tries to understand it on the cellular level, it's just as amazing.

WHERE DOES THE TC FAIL?

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Before entering into the merits of this theme, let me emphasize that I am a firm believer in the TC model, and that I consider the TC to be a vast contributor in the field of mental health. Still, I feel it to be necessary to evaluate the shortcomings of TC's in general, not so much in an attempt to pass a verdict on the TC concept, as to remain aware of the fact that no model or methodololgy, whether we talk about hierarchical TC's, democratic ones, methadone maintenance programs, daycare facilities, or whatever other flavors we have produced over the last few decades, is able to give the sole answer to the problem of drug addiction.

For the purpose of this session I would like to share with you four points of criticism, that hopefully we'll be subject to discussion in the special interest sessions that are scheduled for the next few days.

1) TC's are not realistic when supposing that they can treat almost any addict, provided that they are motivated for treatment and that they don't suffer from severe mental or physical disturbances.

2) TC's tend to misinform prospective residents by raising unrealistically high expectations about treatment outcomes. This misinformation can be hazardous because casualties can be the result of it.

3) TC's are not sufficiently aware of the fact that a number of dropouts have to be considered casualties as a consequence of the treatment they went through.

4) TC's do not take enough responsibility for those who dropped out and became casualties.

Of course I am aware of the fact that these points of criticism do not equally apply to every program represented here, still I feel that although the problem of dropping out is subject to many research programs and has the undivided attention of many staff members, the problem of producing casualties is underestimated by virtually everybody.

Let us get into this subject a little deeper. I remember that during the first couple of conferences that we held, we tried to determine the unique aspects of the TC, compared to the general field of mental health. We came up with some essential distinctions between the TC model and the traditional forms of therapy: deprofessionalization (breaking out of the traditional doctor-patient relationships) and humanization (acknowledging the tremendous importance of concepts such as role modeling, self help, peer pressure, confrontation, ritual participation, etc.). However, another way of describing the uniqueness of the TC is by saying that a TC is a system of interpersonal relations and that it holds its power at these relations which are a prerequisite for allowing personal growth and self-reliance of any individual member. This partial definition uncovers at the same time one of the main shortcomings of the TC model: those individuals who are, for any kind of reason, not able to relate adequately to others can evidently not be treated successfully in such a setting. Unless selection criteria are used to identify these individuals, many of them will drop out disappointed and without any relevant learning experience. This fact is generally agreed upon by most of todays TCs and so we find a number of exclusions such as:

----individuals with serious extensive histories of mental illness

----severely retarded individuals

----extremely violent and aggressive individuals

----individuals who suffer from organic brain damage

Apart from these, more generally accepted cases, it is surprising how many contradictory notions we find in literature bout this subject. Criteria for exclusion that are equally employed and repudiated include conditions as homosexuality, extreme narcissism, depression, hypochondria, etc.

Most of these criteria mount to the same thing: they try to exclude individuals who are not able to be part in the main task of the community as they adopt an interpersonal role that is harmful for themselves as well as for the other members in the TC. By excluding these categories we try to maintain an optimum therapeutic climate and to reduce the number of drop-outs.

Nevertheless, we still have to deal with a considerable drop-out rate. Dropping out of the program apparently is as much a characteristic feature of the TC system as is, for instance, the self- help concept. A lot of research has been done over the last few years into the causes of this phenomenon. Some of the results can be very helpful in refining the selection process. However, I have the impression that many programs so not use the data available. Many TC's that I know still suffer from megalomania in the sense that they believe to be capable of treating almost any addict. This arrogance is dangerous and can be harmful, not so much for the resident who finishes the program as for the ones who drop out and are liable to get into even bigger trouble than they were before admittance.

In this context, the study of Liebermann, Yalom and Miles on encounter groups is mentionable. They pointed out very clearly that casualties actually occur as a result of treatment. There is every reason to believe that unintentionally and unwittingly, TCs have the same problem as the groups described in this study. At this moment I am researching this problem for my own program and I have to say that some of the preliminary results are rather shocking.

Let me give you one example that you will probably recognize very well. Some residents who drop out appear to turn into real missionaries who try to convert all the dope fiends in the street into open, honest TC-minded people. In the scene they are generally referred to as TC-freaks or concept freaks. They would not dream of going back themselves, but their proselytism is impressive.

These people get isolated even in the scene itself and in the end they have less than ever before. They do believe in the TC concept but are unable to take part in the network that exists within the community. They suffer because they dropped out, but at the same time they don't stand a chance when coming back. They have to be considered casualties. Among this group is a considerable number of deaths by overdose.

Other facts show that casualties are found especially among those who have unreasonably high expectations of treatment. These people evidently get gradually disappointed up to the point that they decide to drop out.

I am convinced that a lot of programs are not sufficiently aware of the fact that by creating unrealistically high expectations during the process of induction, they contribute to the risk of creating casualties as well. This is why I would like to make a strong plea for providing new members of the TC with real information and to cease from promising the earth to the resident. I am aware of the fact that positive stimulation of clients during the induction phase is important. In addition, research findings also indicate that among the ones who have high expectations of treatment we find casualties as well as very successful graduates. This inevitably leads to the necessity of trying to gather more knowledge about relevant selection criteria, extended them from the ones I mentioned before to some kind of measure to establish a person's ability, or if you will, inability to go through treatment successfully.

I believe that the chance of success is heavily related to the person's ability, as well as to the opportunity he is given, to relate to others in an adequate way. This may give us an explanation why it is so hard to retain certain categories of residents like monopolizing individuals, narcissists, homosexuals, schizoid personalities or even good-looking women. Either they adopt an interpersonal role that puts them outside of the group, or they are forced into a role that deprives them of the possibility to relate to the group through meaningful communication. They will not get valid feedback and self- disclosure is punished by stereotypical reactions. Eventually dropping out is the only alternative and becoming a casualty is an actual risk.

In my opinion, it is easy to disclaim responsibility for these facts by saying that in the end it is the resident himself who decides whether he stays or leaves. It is us who have to improve our selection criteria, correct our attitudes and try to refine our methodology in order to become more competent in dealing with these problems.

Looking at a TC as a system of interpersonal relations gives us a couple of different angles from which we can look at the questions mentioned above.

In the first place, we are forced to determine whether a person can meaningfully participate in such a system. If not he ought not to be admitted, unless we are able to find a workable compromise between maintaining the TC climate on one hand, and putting some more individual attention into a resident on the other hand.

In the second place, we have to be very much on the alert for scapegoating as this phenomenon is more or less the other side of the shield.

Thirdly, we may be able to gain some more insight in the question why certain residents are so difficult to retain. If it is their interpersonal role that creates the problem of dropping out, we might find ways to deal with it, not by trying to change that role (after all it serves a purpose), but by being aware of the possible impact of such an interpersonal role on the group as a whole and consequently by making it a generally recognized phenomenon within the community.

Finally, I have to say that in my experience, the retention rate of a TC is not mainly dependent upon the quality of the staff members, nor upon the number of "good" residents within the group. The critical variable - to a certain extent - is some kind of obscure combination of group members. It is challenging to find out more about this combination in order to enhance our possibilities of predicting a person's chance of success, failure or damage.

Let me finish by saying that, of course, the question of dropping out and of casualties cannot be solely explained from the angle of interpersonal relations. Many more factors underlie this problem. This one, however, deserves more attention that it had until now.

PSYCHIATRIC SEVERITY AND RESPONSE TO TREATMENT IN A THERAPEUTIC COMMUNITY

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Introduction

Two key questions in drug treatment research today are, first, how much change can be accomplished with people who have different types and severity of problems; and second, which treatment works best for what type of person? The first question acknowledges that we may not be able to accomplish as much with people whose problems are very severe as we can with people whose problems are less severe, irrespective of the treatment provided. The second question suggests that people who have different problems might do better in one form of treatment than in another.

Research on the relationship between psychopathology and treatment has tended to focus on the first issue, that of treatment expectancies. In general, this research has concluded that people with more severe psychological problems show worse outcomes than people with less severe psychological problems, irrespective of the treatment they received. That is, in general we accomplish less with psychologically troubled persons than with less troubled persons. As early as 1972, Pittell and others attempted to identify MMPI variables which could be used to predict success in methadone maintenance. Among their conclusions they stated, "Success in methadone maintenance is more related to the absence of gross psychopathology than to any particular trait or constellation of traits." In 1973, Fisch and others looked specifically at depression and self concept as predictors of success in methadone maintenance. They found that, the more depressed the client, the higher the dropout rate. However, high depressed people who remained in treatment responded positively to methadone maintenance plus counseling, whereas low depressed people did not respond well to counseling.

With respect to the TC, De Leon et al.'s 1973 study found that dropouts from treatment scored significantly worse at intake on several measures of psychopathology compared to residents who remained. Similarly, Zuckerman et al.'s 1975 study found that dropouts from three TCs showed greater psychopathology at admission than those who stayed in treatment.

There is growing interest in the second issue, whether psychologically troubled people do better or worse in one modality than another. A team of researchers at the Philadelphia VA found, initially, that "high severity patients...showed the least improvement and the poorest outcome regardless of which type of treatment they received." In other words, they found no evidence for differential response to treatment. Subsequently they performed additional analyses on the same data and decided that psychiatric severity did predict differential response to treatment. Specifically, they determined that very troubled people did poorly in the TC and did well in methadone maintenance. Their current position is that the longer the psychiatrically severe client remains in the TC, the worse he or she becomes (McLellan et al., 1984).

Another group of researchers at Yale is also working to identify variables which predict differential response to treatment. Consistent with the prior research, they found that troubled people had worse outcomes than less troubled people. However, they found no evidence for differential response to treatment. Troubled people didn't do better or worse in methadone maintenance or TC (Rounsaville et al., 1982).

This study looks at psychological problems over time and the relationship between psychological problems and response to treatment for a sample of substance abusers seeking admission to treatment at Gateway Foundation in Illinois. These data address five questions: First, what is the extent and severity of psychological problems in this group? Second, to what extent is psychological distress at intake a function of drug use or the crises that prompt people to seek treatment? Third, are the worst cases screened out? Fourth, how do symptoms change over time with treatment? And fifth, to what extent does a history of psychological problems predict response to treatment?

This paper challenges the findings of the Philadelphia VA study. Policy recommendations are being made based on the VA data, but these are premature owing to some of the limitation of the Philadelphia VA research and to the existence of contradictory findings described herein.

Keep in mind that high severity means the most severe problems, low severity means minimal or no problems. The actual variables used to define psychological severity vary from study to study, but generally have to do with the number and chronicity of psychological problems experienced.

Method

Eight hundred and eighty-eight substance abusers applied to Gateway for treatment between February 1981 and June 1982. A second cohort of 650 treatment applicants between July 1982 and June 1983 will not be reported on now. Treatment applicants were interviewed by a trained interviewer on the day of their first contact with the program, prior to meeting with a counselor. The pretreatment data are drawn from the structured interview and from the SCL-90, a 90-item self-report symptom checklist. The SCL-90 was readministered one month and three months after admission, and thereafter every three months while the client remained in treatment. In addition, the primary counselor evaluated the client's progress in treatment at the same followup intervals, using a 32-item behavior checklist.

The study sample can be described as long-term users of multiple substances with extensive criminal histories, and with minimal educational, vocational, and other social skills. The sample was 74% male and 64% white. The average age was 24.9 years (+ or -7.0), with a range of 13 to 55 years. Sixty-four percent had never been married, 23% were separated or divorced, and 14% were legally married or living as married. Fifty-six percent had less than a high school education, and 63% had no usual occupation or worked at unskilled or semi-skilled jobs. The clients had been using drugs an average of 8.6 years (+ or -4.8). The vast majority were multiple substance abusers; 91% had used two or more drug classes regularly (at least once a week for a month or more). Thirty-seven percent reported that their primary drug was an opiate, 11% non-opiate depressants, 30% stimulants, 19% marijuana, and the rest other.

Ninety-four percent had engaged in illegal activities in addition to the use of illegal drugs, 89% had been arrested at least once for a non-status offense, and 70% had been convicted on at least one charge. Fifty-four percent were seeking treatment under some form of legal pressure.

Gateway Foundation provides prevention, outpatient and residential drug services in Illinois. This report focuses on the residential program. At the time the report was done, the planned duration of Gateway's residential program was 18 to 24 months. It was a traditional TC with three phases: intensive residential, re-entry, and aftercare.

Results

The SCL-90 taps nine symptom dimensions: somatization, obsessive compulsive, interpersonal sensitivity depression, anxiety, hostility, phobia, paranoia and psychosis.

Somatization refers to a preoccupation with bodily aches and pains. Problems with obsessing or compulsive behavior frequently accompany anxiety or depressive disorders. A person who scores high on interpersonal sensitivity is what might be called "touchy." Phobic anxiety is often more intense and usually more focused than non-phobic anxiety. "Paranoid ideation" on the SCL-90 is comparable to "distrustful." Psychoticism refers to severe thought disorder and delusions. In addition to the nine symptom dimensions, there is a summary score called the Global Severity Index (GSI).

Our first question was, what is the extent and severity of
psychological problems in the group?

Figure 1 shows the mean symptom scores for female and male substance abusers, as well as two comparison groups, psychiatric patients and group of normals. For the total Gateway group, the scale scores range from a low of .62 for phobia to a high of 1.40 for depression. The mean global severity index is .95 (.84 for males, 1.25 for females). All of the scores for the Gateway group are significantly above normal.

The profile of the symptom scores is similar for the substance abusers and the psychiatric outpatients. Reported distress is greatest in the area of depression, followed by obsessive-compulsive, and then by interpersonal sensitivity, anxiety, and paranoid ideation.

The females score significantly higher than the males on all of the symptoms, which is a typical finding in psychology.

Table 1 shows other measures of psychological problems obtained from the structured interview. Again, the females show a higher incidence of all problems.

Figure 1

Symptom Scores for Substance Abusers Seeking Treatment and Comparison Groups

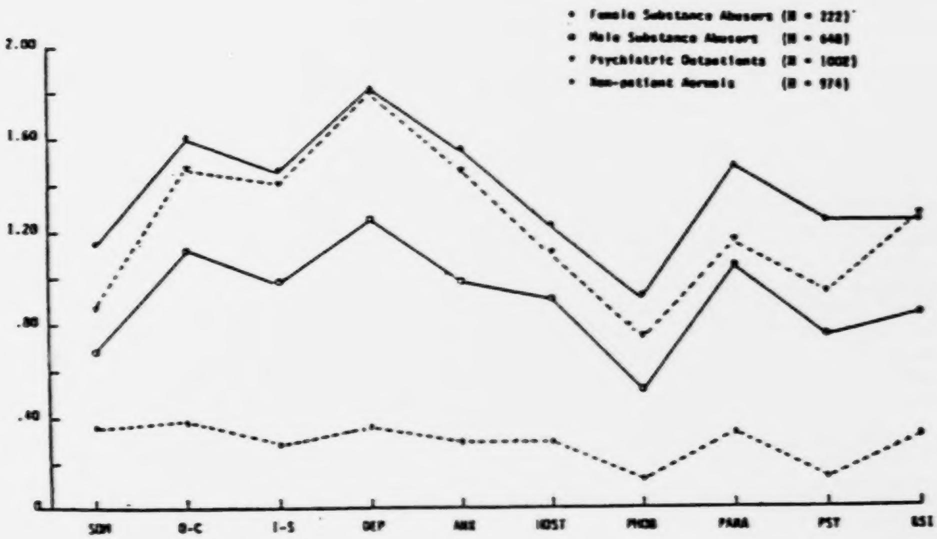
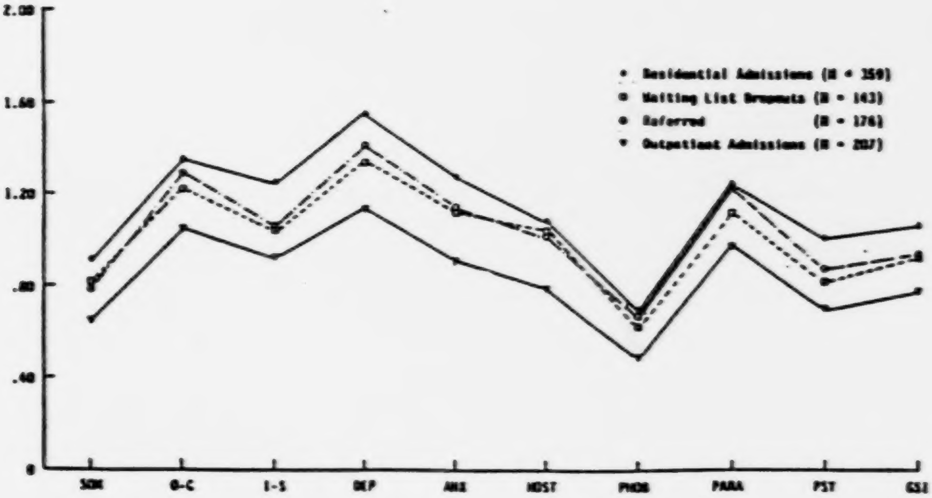


Figure 2

Symptom Scores for Treatment Assignment Groups



The most common problem experienced by this group is confused thinking. The second most common problem is impulse control. Thirty-eight percent have experienced a serious depression. Anxiety disorders are somewhat less common, but 27% have experienced at least one anxiety attack.

It was made clear in the interview that treatment for psychological problems was separate from treatment for drug or alcohol abuse. Seventeen percent had a prior psychiatric hospitalization. This compares to 8% of the Philadelphia VA sample. Another 15% had been treated for psychological problems on an outpatient basis. Again, in the interview we distinguished between a deliberate suicide attempt and accidental overdoses or other drug-related accidents. ç Actual attempts at suicide were made by 28% of the sample. This compares to 17% of the Philadelphia sample. Almost half of the females reported a suicide attempt, and one- fifth of the males.

In summary, the incidence of psychological problems in this group is high, even for a substance abusing population.

Our second question was, to what extent is the psychiatric distress measured at intake a function of the immediate intake situation? In other words, are these abusers really troubled, or do they just look troubled because they're using drugs, coming off of drugs, or because they're in a lot of trouble? The question is an important one for several reasons. We might recommend a different treatment for someone with chronic problems than for someone whose problems are reactive and temporary. In evaluating the effect of treatment, we might want to take into account the fact that some degree of the distress is temporary and that some improvement will occur with time whether or not the person gets treatment. And in comparing the results of different studies, we might want to see whether the study samples are comparable with respect to the distribution of chronic and acute problems. In other words, were the people treated in study A as disturbed as the people treated in study B?

We looked at the relationship between drug use in the month prior to admission; a construct we called "crisis," which represents the amount of trouble the person said he was in with respect to drugs, employment, family, legal, and medical; and the global severity index. We also looked at the contribution of drug use and crisis to the GSI relative to background variables, not including the background çpsychological measures.

Table 2 shows the results of a stepwise regression analysis using the global severity index score as the dependent variable. The model accounts for 37% of the variance in the GSI. Status of intake -- drug use and crisis -- accounts for 13.4% of the variance.

The results indicate, as predicted on the basis of prior research, that intake symptomology is associated with being female, white, and somewhat younger, with less formal education and less job experience. Those who report more distress have a history of multiple, heavy drug use, more often non-opiate. They experienced problems in the family such as illness, unemployment, and violence as well as drug or alcohol use or criminality by family members. While they have been involved in criminal activities, the severity of their involvement is lower than people with lower levels of distress.

In summary: a little more than a third of the psychological distress reported at intake is attributable to the person's immediate situation. About two-thirds appears attributable to demographic, family, and background behaviors. I would conclude that a lot of the distress is long-term, significantly heightened by immediate stresses.

Our third question was, are the worse cases screened out? In other words, does the program systematically refer treatment applicants with psychological problems to other programs or mental health centers? The distinction between a systematic "creaming" of the population and an unsystematic acknowledgment on a case-by-case basis that a given individual is not appropriate for the treatment program is an important one. Gateway sometimes refers people with severe psychological problems to mental health centers. The question here is, does the program try to make its outcomes look better by ç systematically screening out people with poor prognoses? This figure says that the answer is no.

Treatment applicants were divided into three groups: people who were referred elsewhere, people who were assigned to Gateway's outpatient program, and people who were referred to Gateway's residential program. This last group of residential assignees was further divided into waiting list dropouts and those who actually entered a residential facility. Forty-one percent of treatment applicants;ants entered a residential facility, 16% were waiting list dropouts, 20% were referred elsewhere, and 23% were assigned to residential treatment.

Figure 3

Retention Curves for Psychiatric Severity Groups
(Residential Admissions, N=419)

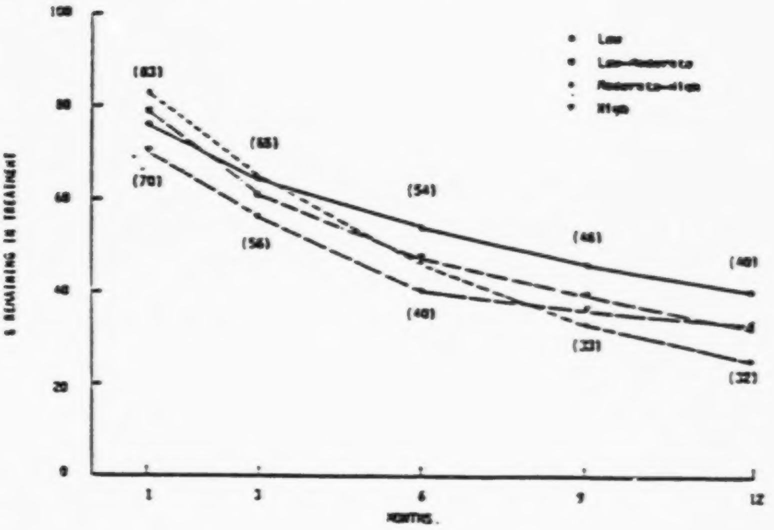


Table 1

Psychological Measures for Substance Abusers Seeking Treatment

Measure	Treatment Applicants		
	Males (N=660)	Females (N=228)	Total (N=888)
Problems Experienced (% yes)			
Became so tense or anxious couldn't breathe	22%	41%	27%
Had trouble with seeing or hearing things that weren't there	33%	40%	35%
Had trouble understanding, concentrating, or remembering	67%	78%	70%
Had trouble controlling temper or violent behavior	57%	64%	58%
Felt so depressed couldn't get out of bed	33%	52%	38%
Number of problems experienced, lifetime: M	2.1	2.5	2.2
SD	1.5	1.5	1.5
Number of problems experienced, past month: M	1.2	1.9	1.3
SD	1.2	1.5	1.4
Treatment for Psychological Problems			
Prior psychiatric treatment: Any inpatient	15%	25%	17%
Outpatient only	13%	19%	15%
None	72%	56%	68%
Prescribed medication for a psychological problem (% yes)	26%	36%	28%
Total time treated (months): M	3.3	6.4	4.1
SD	12.4	17.6	13.3
Suicide			
Attempted	22%	46%	28%
Seriously considered	20%	22%	21%
Never seriously considered	58%	33%	51%
Status at Intake			
Days trouble by psychological problems last month: M	11.5	17.3	13.0
SD	12.8	12.6	13.0
Self-rating, severity of psychological problem (1=not a problem, 4=a serious problem): M'	2.3	2.8	2.5
	.9	.9	.9

We compared the four groups on a large number of sociodemographic and background characteristics, including age, sex, race, marital status, drug and alcohol use, educational, vocational, legal, family, medical and psychological history. In brief, the major difference was between the outpatient group and the others. The outpatient group scored better on virtually all the measures -- although better is strictly relative, since their problems were quite severe. Residential clients reported higher levels of severity in all areas, including psychological problems. Among the clients assigned to residential, the severity of problems was exactly the same for waiting list dropouts and those who entered treatment. However, residential admissions perceived their problems as more severe than waiting list dropouts -- that is, their severity ratings were higher; and 45% of residential admissions were probated to treatment, compared to 10% of waiting list dropouts.

In general, in Figure 2, the outpatient group scores better than the other three groups, and there's no difference among the three groups.

Our fourth question was, how do symptoms change over time?

Table 3 shows the symptom scores at intake and six months after admission for a group of residential admissions. As you can see, there was significant improvement on six of the nine symptom dimensions and the global severity index. There were significant improvements in what could be called the neurotic dimensions: obsessive compulsive, depression, and anxiety, as well as in the psychotic dimension. However, there was no change in what could be called psychopathy: at six months, there residents are still touchy, angry, and distrustful. These findings, by the way, are very similar to the pattern of MMPI findings reported by Zuckerman.

To summarize: people are getting better, but slowly. The symptomology is still relatively high. And there has been no change in those traits often felt to be uniquely characteristic of addicts.

Our last question was, to what extent does a history of psychological problems predict response to treatment? In these analyses, we used two measures of response to treatment. One was time in program. Prior research suggests that time in program is the single best predictor of posttreatment outcomes for TC clients (e.g., Holland, 1983). The longer a person remains in treatment, the greater the probability that he or she will show positive outcomes on a variety of measures. In this study, we're using time in program as a proxy for posttreatment success. Our second measure of response to treatment is the counselor's evaluation of the resident's performance during treatment.

This table shows the intake SCL-90 scale scores for 6 time in program groups, according to when residents dropped out of treatment. The TIP groups are not different at intake except on phobic anxiety. As you can see, it's the low 6-to-9 month group's score that's causing the effect. In general, the 3-to-6 month group scores the highest and the 6-to-9 month group scores the lowest on all scales.

We also looked at the relationship between the intake interview psychological measures and time in program. Three of these measures were correlated with TIP at a statistically significant level, but the correlations were low: -.08 and -.10.

We created a composite measure of psychological severity similar to the one used by the Philadelphia researchers, which reflects number and chronicity of psychological problems experienced. The correlation between this measure of severity and TIP is -.08, which is statistically significant but not meaningful clinically.

This figure shows percent remaining in residential treatment after 1, 3, 6, 9 and 12 months after admission for four psychiatric severity groups.

At the end of six months, 40% of the high severity clients are still in treatment compared to 54% of the low severity group. That 14% difference is the largest at any point along the curve. By the end of 12 months, however, the high severity group is doing as well as one of the mid-range groups and better than the other mid-range groups with respect to retention.

What is clinically significant about these data is the high retention rate for all four groups. At the end of 12 months, 32% of the high severity and 40% of the low severity group are still in treatment. These are excellent rates for a TC.

The counselor ratings tell essentially the same story. Counselors rate the high-severity clients' progress as less satisfactory than the other groups. So there is a difference is their performance. But the actual difference in the ratings is clinically insignificant.

Table 2

Client Predictors of Psychological Status at Intake*

Predictor	r	ΔR²
Demographic		
Sex (0=male, 1=female)	.29	.074
Race (0=white, 1=nonwhite)	-.17	.030
Age at admission	-.05	.001
Family		
Problems in the family while growing up (0-9)	.29	.056
Deviance in the family while growing up (0-3)	.08	.002
Background		
Drug use		
Number-frequency index	.25	.037
Frequency of use, depressants (0=none, 8=4+ times/day)	.23	.003
Duration of use, inhalents	.10	.007
Problems experienced owing to drug-use (0=no, 1=yes)	.14	.008
Prior treatment for drug abuse (0=no, 1=yes)	.04	.005
Criminality		
Most serious conviction (0=none, 6=crime against persons)	-.15	.008
Total months spent in jail	-.14	.003
Employment and education		
Months worked at longest full-time job	-.07	.003
Years of education	-.09	.003
Intake		
Severity ratings (1=not a problem, 4=a serious problem)		
Severity of drug problem	.28	.020
Severity of employment problem	.25	.015
Severity of family problem	.29	.011
Severity of medical problem	.40	.081
Days used drugs past month	.20	.007
% of Variance (R^2)		.374
Adjusted R^2		.356
Number	713	

* Dependent variable is the Global Severity Index measured at intake. A higher score on the GSI indicates greater psychological severity.

Summary

1) The incidence of psychological problems is high in this sample of substance abusers, including suicide attempts, prior psychiatric hospitalizations, and serious problems with impulse control, depression, and anxiety.

2) While a significant proportion of intake symptomology appears to be a reaction to the problems which prompted these abusers to seek treatment, many also have histories of chronic psychological problems.

3) The most seriously disturbed clients are not systematically turned away from the program, although applicants can be and are assessed as inappropriate for the program owing to psychological problems and referred to psychiatric hospitals on a case-by-case basis. From the applicant population, clients assigned to the residential program tend to have the most serious problems in all areas, while clients assigned to the outpatient program tend to have the least severe problems.

4) After six months in residential treatment, significant improvement was seen in six of the nine symptom dimensions and the global severity index. There was no change in the three measures of psychopathy considered by some to be the defining characteristics of addicts -- difficulty with interpersonal relationships, impulse control, and distrust.

5) Neither lifetime measures of psychological problems nor intake measures of symptomology were clinically useful in predicting response to treatment. While treatment outcomes were somewhat less positive for high severity clients, in line with previous research, their retention in Gateway was higher than the average client in the average TC and their rate of improvement was steady in the estimation of counselors. There was no evidence that these clients got worse over time.

Discussion

In the introduction it was stated that the recommendations of the Philadelphia VA group are premature owing to several factors. First, their study involved only one TC and one methadone maintenance program. Independent replication in other programs is required before results can be generalized to the modality as a whole. Second, the TC in the Philadelphia study had a planned duration of 60 days. Mean length of stay was 51 days. Many people would say, that is not a TC. Many people also would not expect serious, long-term problems to disappear in a few weeks. Third, the high severity samples included 28 people in the TC and 30 people in methadone maintenance. In my opinion, policy recommendations should not be based on such small samples.

But the major problem with the study is: there was no effect. The regression analyses which purportedly show that high severity clients get worse in the TC are described by the researchers as "idealized" functions. That is to say, they don't exist. The purported effect is a statistical sleight-of-hand.

A critical problem with this area of research is the lack of a common definition for "psychiatrically severe." If the Philadelphia VA researchers have in mind the Vietnam vet who carries a dagger in his boot and tries to dig foxholes in the living room, I agree that the TC does not do well with that person. I would also hope that some other program might be able to help him.

But a significant proportion of the sample in this study could also reasonably be diagnoses "psychiatrically severe," yet their prognosis with TC treatment is very good. The premature use of such vague diagnostic labels to assign people to treatments will result in a large number of false positives, and quite probably, to the provision of expensive hospital-based psychiatric care to these false positives when less expensive community-based care would be equally effective, perhaps more so.

A second critical problem with this area of research is the application of a single treatment label, "TC," to programs that differ enormously in the strength of treatment provided. It is irresponsible to suggest that the outcomes of a 60-day TC are representative of the outcomes of all TC's. One of the goals of this research should be to determine how strong the treatment needs to be in order to impact the problem to be treated. Presumably, stronger treatments are required to impact more severe problems. Thus, if a relatively weak, 60-day treatment fails to alleviate the problem, it does not follow that a stronger form of the treatment would also fail.

Conversely, if a program is successful in treating psychiatrically severe clients, it's worth looking at what the program does in an attempt to identify effective approaches and procedures. It's my impression that the "confrontive" aspect of the TC obscures some of its other, equally important aspects, such as the constant

Table 3

Symptom Scores at Intake and 6-Month Followup for Residents (N=147)

Symptom Dimension	Intake	6-Month Followup	t
Somatization	.80	.66	1.98*
Obsessive-compulsive	1.26	.93	4.77**
Interpersonal sensitivity	1.15	1.08	1.06
Depression	1.39	.98	6.14**
Anxiety	1.11	.70	5.74**
Hostility	.95	.88	.88
Phobic anxiety	.57	.40	2.95**
Paranoid ideation	1.16	1.10	.73
Psychoticism	.90	.66	3.84**
Global severity index	.95	.73	4.31**

* $p < .05$, two-tailed test

** $p < .01$, two-tailed test

Table 4

Intake Symptom Scores for Residents by Time in Program

Symptom Dimension	Months in Program						F
	< 1 (N=100)	1 - < 3 (N=64)	3 - < 6 (N=54)	6 - < 9 (N=33)	9 - < 12 (N=24)	12+ (N=144)	(5,413)
Somatization	.88	.89	1.08	.65	.74	.83	1.39
Obsessive-Compulsive	1.33	1.28	1.53	1.07	1.20	1.30	1.22
Interpersonal Sensitivity	1.18	1.30	1.43	.84	1.12	1.19	1.81
Depression	1.51	1.51	1.70	1.19	1.34	1.50	1.47
Anxiety	1.29	1.18	1.45	.85	1.09	1.19	1.97
Hostility	1.16	1.04	1.39	.95	.93	.93	2.10
Phobic Anxiety	.65	.64	.88	.31	.69	.60	2.59*
Paranoid Ideation	1.20	1.26	1.52	.96	1.22	1.18	1.67
Psychoticism	.96	1.01	1.18	.72	.95	.93	1.43
Global Severity Index	1.03	1.02	1.24	.79	.94	.99	1.94

* $p < .05$.

surveillance and the labeling and expressing of feelings that make it a very safe and effective form of treatment for distressed people.

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PSYCHIATRIC DISORDER IN THERAPEUTIC COMMUNITY ADMISSIONS

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The pervasive use of drugs in the general population has stressed the need for clarification of psychological factors in the treatment of individuals seeking mental health or drug treatment services. There is an extensive literature documenting the presence of psychopathological signs among drug abusers entering therapeutic communities (De Leon, 1976; De Leon et al, 1973; Zuckerman et al, 1975); and studies have also reported significant improvement in the psychological profiles of drug abusers in treatment and at follow up (De Leon, 1984; De Leon and Jainchill, 1981-82). Nonetheless, the relationship between addiction and psychopathology is still not well understood. Drug abuse may be antecedent, consequent to, or correlated with psychopathology.

A major question remains concerning the actual prevalence of psychiatric sickness and the relevance of psychiatric diagnosis in the treatment of substance abusers. The present paper reports findings that bear upon this question. Psychiatric diagnoses (DSM-III) were obtained with the Diagnostic Interview Schedule (DIS) on a sample of 40 clients entering Phoenix House residential treatment between January, 1985 and May, 1985.

Method

The DIS is the most recent of a series of structured interviews, originally developed for use in a national survey to assess prevalence and incidence of psychiatric disturbance in the general population. The DIS can be administered by trained lay interviewers, as well as by psychiatrists. The interview is read verbatim to the respondent, and covers 43 DSM-III categories. The presence of symptoms are recorded, but severity is differentiated (i.e., subclinical occurrence) as are non psychiatric attribution(s) of the condition. Lifetime and most recent occurrence are obtained for all symptoms.

The DIS was administered by a research psychologist immediately after an individual had been admitted to residential treatment, but prior to transfer to a residential facility. The length of an interview varied directly with the extent of reported problems, but averaged one hour across the sample.

The Sample. The sample of 40 admissions was 65% male, 73% black, 50% were 21-26 years of age, and 45% reported cocaine as their primary drug. (See table 1).

The sample, randomly selected, differed from the Phoenix House residential population in that a greater proportion of female admissions was interviewed and there were few clients under 19 years of age (since the DIS is recommended for individuals 18 years or older).

Phoenix House is the nation's largest treatment system for substance abusers utilizing drug free approaches in both residential therapeutic communities and non residential modalities. Complete descriptions of Phoenix House are contained in other writings (e.g., De Leon and Rosenthal, 1979, 1985).

Results

Table 1 shows that of the 40 admissions, 37 (92.5%) obtained at least one diagnosis, while 3 (7.5%) received no diagnosis. Thirteen (32.5%) obtained one diagnosis only. Nine (22.5%) yielded a substance diagnosis (Drug Dx) only (12.5% Abuse, 7.5% Drug Dependence and 2.5% Drug Dependence + Drug Abuse); and four admissions (10.0%) obtained a non Drug Dx only. The remaining 24 admissions (60.0%) obtained a Drug Dx plus at least one other non drug diagnosis; of these 11 (27.5%) had 2 diagnoses and 13 (32.5%) obtained more than two diagnoses. Thus, virtually all received a diagnosis and most dual or multiple diagnoses.

In DSM-III drug diagnoses exclude alcohol. A Diagnosis of Dependence requires physical tolerance changes in addition to the behavioral criteria for a diagnosis of Drug Abuse. In this paper, the terms substance and drug are used interchangeably.

Table 1

Diagnostic Interview Survey

Sample Characteristics of 40 Admissions
to Phoenix House, NY (1985)

	N	%
Totals:	40	100.0
Sex		
Males	26	65.0
Females	14	35.0
Ethnicity		
Black	29	72.5
Hispanic	7	17.5
White	3	7.5
Other	1	2.5
Age		
18 years	4	10.0
19-20 years	4	10.0
21-26 years	20	50.0
27+ years	12	30.0
Primary Drug		
Heroin	9	22.5
Cocaine	18	45.0
Marijuana	7	17.5
PCP	2	5.0
Alcohol	3	7.5
Pills	1	2.5

Recency of psychiatric disorder was assessed since time of symptom occurrence is obtained on the DIS. Among the admissions with a diagnosis (N=37) all were symptomatic in the last year, and all but one were symptomatic in the month prior to entering treatment. For those who had a psychiatric diagnosis other than or it addition to chemical abuse, 64% were initially symptomatic in the year before being admitted to Phoenix House. Over 20% had a psychiatric disorder in both the past (more than 1 year before treatment) and present, although the diagnosis may have changed.

Table 1 shows the prevalence of all diagnoses for the sample. Among the chemical diagnoses the order of occurrence is Drug Abuse (77.5%), Drug Dependence (47.5%), Alcohol Abuse (22.5%) and Alcohol Dependence (17.5%). Among the nonchemical diagnoses, the order of occurrence is Phobias (37.5%: Social Phobia, Simple Phobia, Agoraphobia with or without Panic Attacks), Antisocial Personality (20.0%), Major Depressive Disorder (12.5%, which includes 5% categorized as Dysthymic), Pathological Gambling (12.5%) and Obsessive Compulsive (10.0%). Percentages for other diagnoses are small (e.g., Mania, 2.5%; Grief Reaction, 5.0%; Schizophrenia, 5.0%; atypical Bipolar Disorder, 5.0%).

Although sample size was too small for statistical testing, differences were observed, mainly by sex. Females more often obtained a diagnosis in addition to that of substance abuse or substance dependence. While males more often received a diagnosis of Drug Dependence, a greater proportion of females were diagnosed with Alcohol Abuse or Alcohol Dependence. Males more often obtained a diagnosis of Antisocial Personality and Agoraphobia, while females were more frequently diagnosed with Simple Phobia. Notably, all but one of the affective and schizophrenia diagnoses were attributed to females. Finally, more cocaine abusers received a Drug Abuse diagnosis only, with no accompanying diagnosis.

Overall, relatively few 1985 admissions enter treatment with a Drug Abuse/Dependence diagnosis only. Most reveal psychiatric disorder in addition to substance abuse or dependence. The most frequent accompanying diagnoses are Phobia, Antisocial Personality, with few cases of psychosis or severe affective disorder. Although symptoms usually appear proximal to the time of entry into drug treatment, a considerable minority have a past and/or continuing history of disorder.

Discussion

The diagnostic findings are consistent with those obtained in a number of other psychological studies. These report the presence of psychopathological signs among drug abusers who seek treatment although there is little evidence of psychosis or severe psychiatric disorder. Substance abuse is viewed as a prominent element in a psychological profile that contains features from both psychiatric and criminal populations. For example, the antisocial characteristics and poor self-concept of delinquent and repeat offenders are present, along with the dysphoria and confused thinking of emotionally unstable or psychiatric populations. Thus, the drug abusers who come to treatment do not appear to be "sick" as do patients in mental hospitals, nor are they characteristic hardcore criminal types, but they do reveal a considerable degree of psychological disability (De Leon, 1984; De Leon & Jainchill, 1981-82).

That psychosis is relatively rare is consistent with research findings and clinical impression. In part, however, it also reflects admission practices in drug abuse treatment centers, which exclude clients who reveal evidence of frank psychiatric disorder on interview. Furthermore, psychiatric referrals to drug treatment centers have, until recently, been limited. Notwithstanding these sources of bias, the prevalence of dual and multiple diagnoses indicate a wide range of psychiatric symptoms requiring considerable attention.

The results on time of occurrence contain implications for differential diagnoses. Most admissions report that their symptoms first appear proximal to entry into treatment. This finding accords with considerable research and hypotheses emphasizing the distinction between longstanding and transient psychiatric disorder associated with circumstantial stress. The majority of substance abusers enter treatment under negative external stress (e.g., legal, health, social, economic) that is highly correlated with symptoms, usually anxiety and depression. These dramatically reduce within a relatively short period of time after admission to treatment (e.g., De Leon, 1984; Rounsaville et al, 1985). Differential diagnosis, therefore, should clarify this distinction between transient and more enduring psychiatric disorder.

Notwithstanding the above, almost a quarter of admissions had longer histories of psychiatric problems. Further illumination of these subgroup differences with respect to diagnosis, retention in treatment and outcomes, await results from larger samples of research currently in progress.

Most admissions view their substance abuse to be their main problem; only a few actually received a substance abuse diagnosis without some other psychiatric diagnosis. This finding confirms a common clinical impression that substance abusers report many symptoms, often as complaints, but they do not recognize or acknowledge the severity of other psychiatric problems. among new admissions, for example, the most usual reason given for seeking treatment is fatigue with the drug lifestyle; only a third seek help for psychological reasons (De Leon, 1976, 1980). However, treatment strategies (such as those emphasized in therapeutic communities), must focus on confronting denial and raising client awareness of the need to address other problems.

Contrary to expectations was the low frequency of Antisocial Disorder. Admissions to the major drug treatment modalities have significant histories of criminal involvement (e.g. 60-80% have been arrested, 50-60% have a legal status at entry, 30% are actually legally referred to treatment from the criminal justice system (e.g., CODAP, 1981). Within this context of criminal involvement the relatively low frequency of a diagnosis of Antisocial Personality appears discordant. This again underscores the importance of further differentiation of apparently similar subgroups of abusers. Thera-peutic community research, for example, has identified at least two antisocial types. In one, drug abuse appears as the important element which initiates, influences or maintains antisocial activity. For a smaller group drug abuse is but one element in a longstanding picture that is fundamentally more character disordered. This distinction, termed Primary and Acquired Antisocial Personality, has obvious implications for diagnosis and treatment (Wexler and De Leon, 1981).

Table 2

Psychiatric Diagnoses (DSM-III)* on the Diagnostic Interview Survey for 40 Admissions (1985) to Phoenix House, NY

	N	%
Totals:		
Any Dx	37	92.5
Substance Dx Only (Abuse &/or Depend.)	9	22.5
Psychiaatric Dx Only (Nonsubstance)	4	10.0
Substance Dx Plus Other Dx**	24	60.0

Diagnosis	%
Substance Abuse (DSM-III)	77.5
Substance Dependence (DSM-II)	47.5
Alcohol Abuse	22.5
Alcohol Dependence	17.5
All Phobias (Social, Simple Agoraphobia with or without Panic Attacks)	37.5
Antisocial Personality	20.0
Pathological Gambling	12.5
Obsessive Compulsive Disorder	10.0
Major Depressive Disorder	7.5
Dysthymic Disorder	5.0
Grief Reaction	5.0
Atypical Dipolar Disorder	5.0
Schizophrenia	5.0
Mania	2.5
Psychosexual Dysfunction	2.5

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* Tobacco Diagnoses are excluded from all analyses. The terms "substance" and "drug" are used interchangeably.

** Substance Abuse and/or Substance Dependence plus other diagnoses (dual or multiple). Diagnoses of Alcohol Abuse and/or Dependence (N=2) considered as "other" diagnoses for this analysis.

That Depressive Disorders occurred in less than 15% of the cohort is also discordant with clinical impression and considerable research showing a relationship between depression and addiction. Again, resolution of this discrepancy may lie in careful differential diagnosis which searches out the distinction between recent (within a year) and long standing symptomatology.

Similarly, the relatively high percentage of Phobic Disorders remains to be understood. Examination indicated that in most cases Phobic symptoms were of more recent onset. However, the sample was too small for statistical analysis of recency by type of disorder. It is possible, also, that the nature of the questions in the DIS probed "positive" phobic diagnosis. This question must be addressed in related studies.

Finally, consistent with earlier studies that report women more psychologically disturbed on admission to treatment, females more often have non-substance diagnoses while males are more frequently diagnosed as Drug Dependent. A hypothesis to be explored in subsequent research is that the grater psychological upset of females may precipitate their admission to treatment before their drug abuse becomes as severe as their male counterparts.

Although obtained in a drug treatment program, present findings ç emphasize the need for parallel studies in mental health centers which focus on the detection of substance abuse problems among psychiatric patients. An understanding of drug use in the initiation or exacerbation of psychiatric conditions is essential to proper diagnoses, management and treatment of patients in mental health or hospital settings.

With regard to treatment in particular, research has convincingly documented the effectiveness of the therapeutic community approach in proving both social and psychological adjustment among clients whose primary presenting problem is drug abuse. Post treatment improvement in psychological status has been highly correlated with positive behavioral adjustment with respect to drug use and criminality (e.g., De Leon, 1974; 1984; De Leon and Jainchill, 1981-82; De Leon et al., 1973; Simpson and Sells, 1982). These findings obtained on drug abusing populations with psychiatric symptoms have implications for employing similar treatment strategies for psychiatric populations with substance abuse problems.

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DIAGNOSIS & TREATMENT OF THE DUAL DIAGNOSIS CLIENT

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The traditional gap between mental health and chemical dependency which has spawned two types of service provision is closing. Practitioners in each of the two fields are finding that there is considerable crossover and overlap of chemical dependency and psychological problems. Patients with significant psychopathology are either appearing or else being recognized with increasing frequency in TCs whose treatment focus is chemical dependency. The reasons for this are many and complex, but certainly the increased prevalence of substance abuse in the general population, movement of mental health professionals into the chemical dependency field, and inadequate public services for the dual diagnosis client are contribute to this phenomenon.

The TC treating substance abusers must begin to look more closely at the shifting population of its clientele. Early forms of the substance abuse TC (e.g. Synanon) were composed of a far more homogeneous resident population, primarily heroin addicts with criminal history. The highly confrontive Synanon "games" and other elements of the Synanon TC were appropriate treatment methods for this "hardened" population, which the mental health community had labeled "untreatable." Diagnosis during this era of the TC was made by drug type used; you had an alcohol problem, a "drug" problem or a "psychiatric" problem.

Currently most modern TC's treating substance abusers recognize the presence of a "dual diagnosis" subpopulation within their larger "single diagnosis" chemically dependent population. It is generally believed that the "dual diagnosis" subpopulation is a small percentage and in many cases "dual diagnosis" in the TC is a term for someone with dramatically overt psychopathology. It is our contention that this dual diagnosis subpopulation is actually quite substantial. In order to effectively treat this increased segment of the TC population it is essential to consider both elements of the dual diagnosis so there is awareness about how both psychological problems and substance dependency contribute to the patients difficulties. To treat only the substance abuse problem or only the psychological problem is incomplete treatment which will result in diminished, and sometimes failed treatment. It is our observation that most TC's assume that the great majority of their residents are "single diagnosis" substance abusers; psychological issues are not systematically dealt with in the treatment program. Without adequate awareness and treatment accommodation to the character and symptomatic problems of the substance abuser simple cessation of substance abuse behaviors will lead to recidivism or substitution of other substances to abuse.

Given our premise that the current composition of the TC is far more heterogeneous and has far higher presence of the dual diagnosis patient, diagnosis and treatment become more challenging. In the examples of diagnosis and treatment which follow it will be our contention that although substance abuse and psychological issues are inextricably interwoven in the real person, it is clinically useful to separate the two in order to more accurately assess the features of each. In addition, diagnostic separation and consideration of the substance abuse and psychological elements of the clients' problem lead to more accurate and "three dimensional" understanding of the relationship between the two, i.e. what aspects of the patient's problem is caused by substance abuse and what aspects of the patient's substance abuse is symptomatic of his or her psychological problems. Clearly, this set of assumptions about how to approach the "whole" patient (rather than simply a small portion of his problems) leads to an increased sophistication and effectiveness in actual treatment.

DIAGNOSTIC ISSUES

In order to best accomplish this goal of more sophisticated diagnostic consideration of the dual diagnosis patient an admission assessment prior to acceptance into the program is essential. Our experience at Walden House has led us to specify three levels of admission assessment: 1) clear exclusion, based on some patient problems which would make use of the program impossible; 2) a "trial acceptance" group which has demonstrable issues which are problematic for the milieu, but with complete diagnostic assessment and "specially tailored" treatment plans may effectively use the program; and 3) a "clear acceptance" which requires consideration of how their character and pathology or personality will interact with the milieu. These three categories will be discussed with examples.

CLEAR EXCLUSION

At Walden House we exclude five basic kinds of presenting problem: First, is the patient with organic problems serious enough to prevent effective communication or the functioning in the daily aspect of the TC. In this category there are the seriously hyperactive or attention deficit disordered client, the mentally deficient or seriously retarded individual, the organ-ically delusional or affectively disturbed patient, and the large group of brain lesioned patients who have a variety of neuropsychological deficits serious enough to warrant exclusion.

Second is the psychotic patient, which frequently includes patients who are not overtly psychotic on admission screening but are clearly determined to be after assessment. Third are patients with demonstrable suicidal or homicidal ideation. This kind of patient with demonstrable suicidal or homicidal ideation and history may be situationally intensified by the circumstances often surrounding admission (loss, confrontation by family members, criminal prosecution) and may not actually have a problem which will continue beyond admission and stabilization within the milieu. As a general guideline patients with histories of "hysterical" attention-getting suicidal gestures in a context of interpersonal disappointment or frustration will often become difficult management problems in the TC. Residents are quick to sense the manipulative nature of this behavior and may be intolerant or punitive towards it. The presence of prior suicidal behavior or even current passive suicidal ideation should not be automatic exclusion criteria. It is not uncommon in our experience to see patients who present passive suicidal wishes but are clear about not having active intentionality.

Finally, there is a group of "management problem" patients which may include both administrative and clinical problems. Patients with histories of arson are not accepted at Walden House for obvious reasons. Patients with histories of child molestation are excluded both because the legal liability inherent in exposing these patients to minors, but also because of the considerable stigma attached to the child molester by residents who may be aggressively intolerant of this problem.

TRIAL ACCEPTANCE

The second category is necessarily broader and somewhat harder to define. It includes, as does the exclusion category, patients who are at risk to be harmed by the treatment milieu, as well as those who represent management difficulties. From a diagnostic standpoint, these individuals may be those with phobias which impinge on participation in the community, those of borderline intelligence, those with significant neurologic impairment that may be hard to manage or treat and those with affective disorders which are sub- acute, among others. Aside from these individuals, who present relatively clear symptoms, are a number of others who may be somewhat harder to identify. They may or may not have histories which include treatment for psychiatric difficulties. They are nevertheless distinct and their distinctiveness may be hinted at very easily in their contact with the TC. They may be described by intake workers, for instance, as evoking "different feelings" in the interview than the "average" prospective TC candidate. This group is hard to describe succintly. However, for the purposes of patient management, their most important trait is a tendency toward situational, stress- related decompensation, triggered by any of the following:

(1) severe self-blame;

(2) low tolerance for intense affect;

(3) poor ability to objectify authority demands; and/or

(4) confusion between self/other boundaries under stress.

CLEAR ACCEPTANCE

Virtually all TC's, of course, accept their clients on a trial basis and subject them to an orientation period in which they must "earn their way" into the community. The term "clear acceptance," therefore may seem a misnomer. Nevertheless, a large group of individuals who petition for TC membership tend to be seen by the staff, both by history and presentation, as good TC candidates. The question of eventual treatment success is typically conceived of by the staff almost exclusively in terms of the client's motivation and willingness to change. While this is an appropriate conerstone of TC treatment, a large number of the patients in this "majority" group suffer from conditions which are psychologically debilitating, attention to which may be vital to the patient's success. These conditions run the gamut from learning disorders through phobias or anxiety-related orders which may not emerge in the TC environment (i.e., agoraphobia or sexual dysfunctions) to sub-clinical, chronic (sometimes called "characterological") depression. The primary danger with this group is that the problem may be either ignored completely or defined by staff as simple by-products of the presenting substance abuse problem. Lack of clinical work on these problems may eventually spell disaster for the patient's recovery.

It is our strong conviction that focusing assessment at the ear liest phases of treatment is the wisest use of typically limited resources. A three level "funnel" system is optimal. In this type of system, each prospective client is initially assessed by a combination of structured interview and an objective psychological inventory; the object being to identify psychopathological symptoms, past or present.

Both interview and inventory can administered by paraprofessionals with appropriate training and review by a professional. A good model of a structured interview designed for the addicted populations is the Addiction Severity Index (McLellan, Luborsky, O'Brien, et al, 1980).

Standard "gross pathology" psychological inventories include the Beck Depression Inventory and the Hopkins Symptoms Checklist, also called the SCL-90 (Derogatis, Lipman and Covi, 1973).

In the second level of the assessment system, those individuals (at this point, either prospective or accepted clients) whose responses indicate histories of pathology may be administered more involved psychological inventories (i.e. the MMPI or the MCMI) and be interviewed in more depth by a trained psychodiagnostician.

The third level of assessment is reserved for individuals who present the most complex diagnostic questions. This is the level of the traditional in depth evaluation by a psychologist or psychiatrist and may include full-scale personality and/or neuropsychological testing.

TREATMENT

Once a dual diagnosis patient has been accepted into the TC, the challenge becomes one of determing how many of the patient's clinical problems may be reasonably worked with during his or her stay in the TC and which are more approriately dealt with in aftercare.

The next question becomes how much to modify or augment the basic program to meet the patient's clinical needs. The basic tools available for this may be remembered by the mnemonic phrase "To Gloss Over May Mean a Terrible Outcome," deciphered as follows: To (meaning Therapy or individual psycho-therapy); Gloss (inclusion in special groups); May (medication); Mean (modification of the milieu including modified assignments, specialized exercise programs etc.) a Terrible (training, particularly for learning disabilities or other neurologically-related conditions); Outcome (outpatient or aftercare often insufficiently emphasized both by staff and resident, as the individual reaches the later stages of the TC program.)

Although it is not possible, within the scope of this paper, to be comprehensive, an example dealing with a reasonably common clinical syndrome may help illuminate this concept.

One type of patient which seems to be seen with regularity in the TC is the individual suffering from an attention deficit: This phrase is the latest in a long series, including "minimal brain dysfunction", "hyperkinesis" hyperactivity" and specific learning disability", used to label an often hard-to-define cluster of symptoms. Fundamentally these symptoms revolve around pervasive (through typically fluctuating) difficulties in focusing attention, which usually manifest in problems with impulsivity, disorders of memory, thinking and/or speech. In children this problem often includes (and normally comes to the attention of adults because of) difficulties with behavioral hyperactivity. Until recently, it was widely believed that most such children "grew out" of this problem. However, it is now understood that although behavioral hyperkinesis in most cases does subside with age, attentional problems persist into adulthood in a relatively large subgroup. This subgroup is now understood to be at very high risk for both chemical dependency and personality disorder; in particular the antisocial personality disorder. Interestingly, this group often migrates toward amphetamine, one of the pharmaceutical treatments of choice, and often reports a paradoxical calming effect for moderate doses.

Applying the mnemomic phrase "To Gloss Over May Mean a Terrible Outcome," we find: (1) "To" (therapy) - once the condition can be identified, the individual with appropriate intelligence and abstracting skills can often make good use of individual therapy. Lifelong self-esteem deficits often cluster around school failure, parental frustration and a chronic sense of "not being quite right." (2) "Gloss" (special groups) - when a sufficiently large group of such individuals exist, a special on-going group can help residents cope with the stigma of having a brain disorder and provide valuable peer support. (3) "May" (medication) - Medical treatment of choice are several of the more activating anti-depressant drugs, magnesium pemaline (a slow acting amphetamine, therefore perceived to be less attractive for abuse) and ritalin. Although ritalin is obviously less desirable for this type of patient because of its abuse potential, some individuals with severe cases may not respond adequately to the other medications. Individuals, especially adolescents, with marked problems with impulsivity may benefit from low doses of an anti-psychotic drug such as mellaril. One encouraging note in our experience has been the observation that although some individuals appear to need medication for indefinite periods and deteriorate markedly when medications are withdrawn, others seem to make and maintain great gains with drug trials of several months duration. Use of medications such as these obviously requires impeccable in-house security and the ability to work closely with a physician highly knowledgeable both of this conditions and residential drug treatment. (4) "Mean" (modification of milieu) - Some attention - deficit patients may experience deterioration of functioning in specific circumstances. Some, for instance, become especially irritable and even prone to rages with fatigue in the late afternoon. Others may have a very low tolerance for performing work that requires even moderate concentration in crowded or noisy conditions. To the extent possible, these needs should be honored without turning the patient into a privileged special case. There is also some suggestion that moderate, regular exercise may help these individuals feel less "fidgety" and therefore, may be able to help them concentrate. (5) "a Terrible" (training) - A variety of approaches to developing auditory and visual memory may be helpful. With treatment, these individuals are often more amenable to educational remediation, since they may be able to learn academic material more successfully than was ever previously possible. (6) "Outcome" (outpatient, or aftercare) - focus on attention - deficit related problems will often be vital to treatment success in these cases. Abuse potential of medications obviously becomes crucial once the patient leaves the structure of the TC. Continuation of individual therapy and peer support groups may be very important, since (as with chemical dependency) the temptation may be powerful to hope the difficulty will "go away", rather than remain as the chronic lifestyle problem.

CONCLUSION

The modern TC is clearly in a state of flux. Pressures from the mental health system to deal with chemical dependency as a psychiatric illness has forced (and will continue to do so) the TC to become more sophisticated in diagnosis and treatment of the dual diagnosis patient. It is our hope that the preceding thoughts on diagnosis and treatment of the dual diagnosis client will increase the sophistication and effectiveness of the TC in dealing with the population.

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THE USE OF PSYCHIATRIC MEDICATIONS IN A DRUG FREE TC

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The purpose of the present paper is to address the issue of using medication in a drug free therapeutic community, when it is, appropriate, and how do we differentiate between drug use/abuse and medically supervised chemo-therapy for people whose drug addiction is secondary to their fundamental problem of psychiatric or psychological disorders.

It is common knowledge that the therapeutic community approach was made popular by British psychiatrist, Maxwell Jones to treat schizophrenics, by recognizing that to some degree they are able to help each other when they are protected against competition and manipulation.

We also know, however, that the traditional aggression-encounter and confrontative style of the ex-addict run therapeutic community is inappropriate for people who are more fragile or suffering from a psychotic disorder. They cannot cope with a probing - confrontative style which would be undermining and destructive.

Odyssey House began in New York City in 1966 and now has programs in five states in America, two in Australia and two in New Zealand. The basic philosophy on the use of medication is common to all the Odyssey House programs. However, the author of the present paper is the Director of the Victoria, Australia program and will primarily focus on the Australian/New Zealand experience which represents approximately 300 residential treatment beds and seven years of operation since 1977.

The founder of the Odyssey program, lawyer/psychiatrist, Dr. Judianne Densen-Gerber was able to distinguish the Odyssey method from other drug rehabilitation programs by describing it as a "Psychiatrically oriented therapeutic community for the rehabilitation of drug addicts". The two major ingredients that qualify the term "psychiatrically oriented" are:

1. The staffing structure includes both the university trained health professional, and the ex-addict person on a 50/50 basis.

2. There is an extramural quality control and psychiatric supervision of each case on a regular basis.

Every one is given a psychiatric and psychological assessment during the first 2-6 weeks of the motivational stage of the program and a long and short term treatment plan is devised by level I of the treatment phase. This will be described in greater detail later in the paper.

We are not a psychiatric hospital, we believe strongly in accountability and everyone is held responsible for their actions at all times. Consequential thinking is considered a major part of treatment and a healthy sense of guilt for deviant behavior is employed.

The basic concept is that we do not consider drug addiction as the whole problem. Our aim is to treat the underlying emotional disturbance of the addict, which often is an underlying sense of futility and dependency, but can also be related to a more complicated psychiatric condition. Being drug free is no big deal. Residents do that from day one of the program. The goal is to remain drug free by coming to terms with the cause of the problem and developing a commitment to upward mobility, first identify one's potential and then maximize that potential, regardless of how great or how little it may be.

There are three types of treatment modalities within the program.

1. The adolescent program for 13-17 year olds.

2. The adult program for 18 year olds and up.

3. The parent's program for single parents or married couples with children.

All three programs interact as one large extended family. The program has three phases - pre-treatment or motivation phase, the treatment phase and the re-entry phase, with each phase having three levels.

It must be noted that there is often overlap in these figures. The child abuse victim may also be psychotic etc.

Our figures show that 8% of those interviewed for induction are assessed as unsuitable to enter the Odyssey House program.

At the present time 10% of residents are on psychotropic medication, all of them for depression.

Our experience shows that if we allow the resident population needing psychotropic medication to exceed 20% of the total population it becomes disruptive and difficult to manage. Thus we have a screening out process which is rigidly applied in three categories.

1. Those who are acutely suicidal.

2. Those are acutely homicidal.

3. Those having a history of arson.

Anyone who is seen to be a potential danger to themselves or others is automatically referred through our psychiatric consultants to a more secure psychiatric setting whenever possible.

Close communication between the clinical staff at the House and the admission team is essential to determine what the climate of the House is as to whether we can make concession for a more disturbed person, following the common Therapeutic Community for the individual.

It is very positive, productive and highly therapeutic in the environment of the large extended family of the therapeutic community to teach that the healthier family members can look out for and make concessions for the not so healthy. Thus the anti-social personality learns care, concern and sensitivity, while the more fragile person benefits from the structure necessary to enable them to stabilize on medically supervised medications.

However, it is important not to create a situation where the staff's time becomes so taken up with the far more difficult individuals at the expense of the quality of treatment of the bulk of the population.

A tremendous amount of time and energy went into developing the repuattion and credibility of the drug free therapeutic community approach in this part of the world, for years blockade methadone was the only available treatment for drug addicts and there has been a strong lobby for free distribution of heroin for registered addicts.

Lack of facilitaies and basic lack of interest from the psychiatric and medical fraternity can create a situation where the therepeutic communities beocme a dumping group for psychiatric patients with secondary drug abuse problems.

Under the Victorian Drug and Alcohol Dependent Persons act of 1968 the only altaernative for the judge to recommend treatment was to the Government methadone program.

With this in mind we must we must be careful how we describe the use of medication. We have often found our drug free status naively challenged in public speaking situatioins because we allowed the residents to smoke cigarettes and drink coffee. This aside the fact is that we do not use any drugs for the treatment of drug addiction per se. However, we would not deprive a person of necessary medical attention separate and apart from their addiction whether that be physiological or psychiatric in nature.

Normally we would not detoxify addicts applying for treatment. We would encourage heroin addicts particularly to undergo "cold turkey" withdrawal, understanding that most of them can handle it and have had the experience numerous times in the past. (No-one has ever died of heroin withdrawal). Those who feel they need detoxification would be referred to a detoxification hospital prior to induction to Odyssey.

As in most things there are exceptions to this as well. Due to the tremendous lack of facilities we utilize short term detoxification supervised by our in house general practitioners in three situations and when external facilities are unavailable.

1. Barbiturate withdrawal - which can be fatal if not handled properly.
2. Pregnant addicts.
3. Adolescents - Odyssey has a 24 hour induction service. We never turn away kids.

Assessment Procedure

The consultant team consists of two sessional psychiatrists and two sessional psychologists who assess those people who are already resident in Odyssey House. The Clinical Co-ordinator, who is also a psychologist, liases between the staff and the consultants.

The co-ordinator is able to give the consultants feedback from the staff as to the person's behavior in the facility and is able to implement recommendations from the consultants in a way that is consistent with the structure of the program. The staff person at the Admissioins Center liases with a general practitioner and two psychiatrists in private practice, as well as with the Clinical Co-ordinator and the Clinical Director.

The assessment process begins at the Admissions center with a detailed interview conducted by a senior resident of the program. Information is obtained about the addict's drug history, employment record, criminal offenses and family relationships. The interview then moves onto gathering a history of previous treatment, specifically any psychiatric trreatment. The interviewer will at some point in the interview discuss what are called the four "red lights", which are attempted suicide, homicide, assault or arson. The red lights are referred to as such because it is a signal that a person presenting with a history of any of the above is unsuitable for the Odyssey House program. It is not uncommon of course for addicts to have overdosed or assaulted someone, however the purpose is for the interviewer to pass back the information which is evaluated firstly by the Supervising staff employed at the House. As will be appreciated, it is important to distinguish between the addict who accidentally overdoses and the addict who makes calculated and deliberate attempt to suicide. In our experience the latter type of person frequently cannot cope with the confrontational style of the Therapeutic Community, but rather needs a gentler, more supportive approach. Anyone who is assessed as being highly likely to act out upon themselves or others is offered referral to alternative psychiatric treatment. Where there is uncertainty regarding the evaluation, the person is referred firstly to a general practitioner who is part of our team.

The general practitioner acts as a further screen, as it is important to only refer on for a psychiatric assessment when necessary as there is a waiting period for such appointments. At that point, the district assessment would make a recommendation for either treatment at Odyssey House, or alternative referral. A further consideration in the close liaison between the external consultants and Odyssey staff, is the climate of the House. At some points when the mix of residents being treated gives a sound foundation and atmosphere in the House, the community can tolerate someone coming into the program whom we may later find psychiatrically unsuitable. At other times, if the community itself needs a lot of time then it may be decided that to admit someone who is only on the borderline of suitable is not in the best interest of the community.

To summarize, these kind of decisions are rarely clear cut and there are occasions when it may be worthwhile to give the individual a chance to prove themselves. It is a matter always of balancing the needs of the individual with those of the therapeutic community, bearing in mind that Australia generally has proportionally fewer alternative treatment resources than are offered elsewhere. The next step in the assessment process is that if the individual is accepted into the program, irrespective of previous psychiatric treatment, they will be evaluated by our consultant team. Sometime in the first four-six weeks, the individual will have a physical examination, will be assessed psychiatrically and given an intelligence test. Personality testing may also be done at this time although more typically that will be carried out later in the program. That information is then assembled and available to the staff who will run the resident's Probe group. The Probe is the "rite of passage" into the community, where the resident is asked to tell us as much about themselves and their past life as they can.

From the Probe group and the consultant evaluations a treatment plan will be formulated for the individual which is reviewed by the treatment team weekly, the full time staff monthly and by our extramural consultants every six months. Further referrals for more intensive assessment can be made at any time that problems arise with the individual that the full time staff feel some wish to have further input on. Most typically a resident will be referred for a medication assessment at the consultant psychiatrist by the consensus of the staff after the resident has been in the treatment phase for a period of time. As will be illustrated by these vignettes typically these are individuals who have demonstrated their motivation and willingness to address their personal problems by being in the program not less than three months and by participating to the best of their ability.

Psychotropic medication is seen as facilitating a person's progress and increased participation in the program. This is, it is our view that there are occasions where an individual cannot rise above themselves without assitance in the form of medications. It must be stressed that the expectation that an individual is responsible for themselves and their behavior is maintained.

The following case vignettes illustrate our approach.

Case No. 1

Ms. J.B. entered Odyssey House at 27 years of age in March 1983. At that time she had been caring for one child, while another child remained in the care of her mother. She had been to two detoxification centers previously and had convictions for prostitution and self-administration of heroin.

J. was the third of three children raised by her mother after her alcoholic father deserted the family during her childhood. J's. drug use began at 11 years of age with alcohol and progressed through adolescence to using an assortment of drugs until she began using heroin at 21 years of age. J. had been using heroin daily for six years prior to her induction to Odyssey House.

J. was highly motivated to complete the program, but very emotionally labile. She had difficulty settliing and was quite scattered in her thinking, which was reflected in her intelligence testing scores. J. tested as having average intelligence, however she showed quite a wide range in performance. (Verbal IQ 104: Performance IQ 116) She was diagnosed as Inadequate Personality Disorder with neurotic depression.

J. was depressed about her inability to manage the demands of the program which confirmed her low opinion of herself. After a period of being drug free for three months it was evident that J. was unable simply to pull herself out of her present difficulties. She had been interviewed by the consultant psychiatrist on several occasions over the period and it was the opinion of both the psychiatrist and the staff that J. may benefit from medication.

Personally testing was carried out by our consultant psychologist who also agreed that a trial of medication may assist in stabilizing J's affect. J. was prescribed a tricyclic anti-depressant and reviewed regularly by the psychiatrist.

While J. remained a fairly emotionally fragile person, she was able to complete the program. During her residence in the program J. was also made a Non-Level Trainee, which is another type of modification to the program. NLT status means that the resident does not have responsibilities for other residents treatment. NLT status is used when an individual is of low intelligence or where an individual has fragile reality testing. In these cases it is felt that they should not be involved in giving therapeutic direction to lower house residents. It should be noted as in the case of J. that most NLT's compensate by working extremely hard in the areas where they do carry responsibility. J. has now been a Level IV graduate of the program for 12 months. She lives in a co-opeative with other graduates, has steady employment, which she enjoys and has been drug free.

Case No. 2

Ms. L. is a 29 year old woman with two children who entered Odyssey House in March 1948. L. is the first of four girls all of whom have used drugs. L's drug use began at 15 years with cannabis progressing through adolescence with an assortment of drugs.

At 20 years she commenced daily use of heroin which she continued for the next eight years until her induction into Odyssey. L. had previous convictions for theft, burglary and possession of drugs of addictiion. In the three years prior to Odyssey, she had made three short-lived attempts to remain drug-free at other treatment centers.

On entering Odyssey House, L. presented as a capable mother who was depressed. L's husband of eight years had committed suicide three years previopusly and it was evident that little of the grief of that loss had been processed. She was diagnosed as Antisocial Personality Disorder with distorted grief reaction. She is of above average intelligence. L's father had died during her adolescence and it was obvious that drugs had been a way to block profound feelings of hopelessness and grief. After a period of being drug free for four months, it was felt by the staff that L. should begin anti-depressants while she continued to work in therapy on her grief. Subsequently L's sister was murdered. L. is an extremely capable woman, and suffered from clinical depression. The medication lifts her mood sufficiently for her to be able to work in therapy and resolve her grief so that she will not need the medication in future. L. at present still had many issues to face, but she is a senior resident and gives a great deal to others.

Both these case vignettes illustrate situations where the resident requires medication for clinical depression only until they have resolved issues which led to the depression itself. There are also a very small number of instances where medication is required by the individual even after graduation and the person continues to required minimal psychiatric monitoring. The use of lithium for manic-depression or minimal amounts of phenothiazenes for borderline psychosis are examples.

In conclusion, it is worth reiterating thaat these are individuals who are unlikely to receive adequate treatment elsewher if they are turned away. We consider it is worth the effort of the staff and the therapeutic community to extend and reach out to those who are in a little extra difficulty.

A MULTIMODALITY APPROACH TO TREATMENT IN A THERAPEUTIC COMMUNITY

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"Addicts have too much eros and too little agape to begin with and much too short a dose of charis."
—Lewis Yablonsky, The Tunnel Back: Synanon, 1965

The therapeutic community (TC) has offered a global view of rehabilitation, where drug abuse and criminal behavior were signs of social disorder, family disturbance and individual maladaptation. It was thought that the TC provided a growth environment where the member could progress in emotional growth, from child, through adolescence to adult. Some have thought that the TC is a microcosm of society, where value contradictions, class disharmonies, socioeconomic inequalities, prejudice and sexual stereotyping may function as in the larger society. Paradoxically, the TC provides an elaborate surrogate tribal family that fosters identity, stability, growth and development. some have characterized the TC members as like-minded (Frye 1984a,b).

Although the term therapeutic community is generic, most American drug-free TCs for addicts trace the history of the modality to the early days at the Synanon facility in Santa Monica, California (Yablonsky 1965). A National Mental Health Team found a "miracle on the beach" there which showed success in treating the heretofore untreatable heroin addict (Bassin 1984). Public funding for similar programs subsequently became available. there TCs based on the Synanon model trace their development in one of two ways: 1) the East Coast Model pioneered by Daytop Village in New York City (developed by David Deitch, a Synanon alumnus) and continued by the founding of other TCs by Daytop's staff and graduates, and 2) the West Coast Family Model founded directly by other Synanon Graduates and Splitees (those who left without graduating). Examples of the latter were the Mendocino Family TC and the Napa Family TC in California. The major treatment tools of both models have been Synanon inspired and, with some modifications, have been confrontation group therapy, encounter or game; verbal haircuts or critical feedback to the client; cognitive concepts and seminars; a belief system emphasizing honesty, responsibility, self-reliance and trust; rituals and totems; and drug abstinence values. In addition, there has been limited differentiation between the care-giver and the recipient and rewards for "good" behavior and punishment or discipline for "bad" behavior. Therapeutic community leadership has often been charismatic, leading to increased group cohesiveness and member dedication (Frye 1984a,b).

Therapeutic communities were part of the multimodality programming for the treatment of addiction developed in the late 1960's as a response to the factionalism that had developed among different methods of treating opiate addiction. Early multimodality programming consisted of an organized system of clinics with a central intake unit and special support units under one administrative authority (Senay 1981). Along with TCs, multimodality treatment approaches included services such as detoxification, mental health counseling, group therapy, confrontation therapy, methadone maintenance, narcotic antagonists, vocational counseling, social work and religious counseling (Frye 1985; Veterans Administration 1973).

Outcome studies have shown the effectiveness of the TC modality (Frye 1984a), and length of time in treatment seems to be the major variable discovered which may predict successful treatment outcomes. Holland (1983) indicated that the next generation of outcome research should go beyond the question, "Does the program work?" to identifying how much change can be accomplished, with what types of clients and using which procedures.

In the past, the traditional resident in the TC has been the heroin dependent person. During the 1970's, stimulant abusers became representative in the TC population, and in the 1980's polydrug abusers are becoming as numerous as the opiate dependent person, bringing different demographics and characteristics. TCs are struggling to adapt to the special needs of managing the polydrug abuser. comprehensive treatment of polydrug abusers generally requires the strategic use of a variety of techniques (Frye 1984a).

It is the goal of this paper to present a multimodality approach to programming in a therapeutic community that will consider the special needs of the polydrug abuser. This approach is based on experience with multimodailty programming for the last several years in the Ayrie Therapeutic Community administered by the Veterans Administration Medical Center in Denver, Colorado. The Medical Center is unique insofar as multi-disciplinary professional and technical terms are available to work with the Therapeutic Community.

Theoretical Basis for Multimodality Treatment Planning

As Tiger (1979: 173) has pointed out, humans, being more complicated animals, must have more instincts than others, and "our brains are higher brains, more efficient at diagnosing and ferreting out possible hazards, impediments, problems (moral and factual) and demons and shades with which we can be harassed. It becomes all the more important then that we possess an overriding internal censor of all these mean and depressing thoughts so that we are not immobilized and disconsolate forever." Addictions may activate the "overriding internal censor."

Charlesworth and Dempsey (1982) suggest that addictions are not a phenomenon of the few but a major phenomenon including many humans. These data suggest a need to find alternatives, rather than just abstinence. A void is created when an individual is asked to give up his addictive resources, whether it be alcohol, licit or illicit drugs, food, gambling, risk-taking, etc. Addictions appear to affect survival mechanisms which alter consciousness and are thus highly resistant to change through treatment (Frye 1980a). a multimodality treatment approach designed to address the problem of addiction may utilize submodalities or experiential therapies which may provide compensation for the lost addictive resource.

Two consonant hypotheses or addiction models are used as a theoretical basis for treatment planning. A sociobiologic theory of addictive behavior (Frye 1981a) is interdisciplinary and grounded in social evolutionary theory. This concept utilizes phenotype (observed behavior), genotype (heredity) and environmental factors (P=G+Ef). This theory hypothesized that the ability to withhold unpleasant sensations from oneself may permit the individual to take steps to overcome unpleasant stress producing stimuli. The sociobiologic theory postulates that addictive behavior patterns is a syndrome based on genetically adaptive behavior patterns and is a social behavior with biological foundations. The behavior alters the individual's perception of stressful situations and promotes behavior change toward objects and circumstances in the environment that are perceived to be threatening. In the Milkman and Sunderwirth (1982) Interdisciplinary Addiction Model, addiction is defined as self-induced changes in neurotransmission which result in problem behaviors; and three addictive types are identified which cluster around excessive needs for "arousal," "satiation" or "fantasy" experiences. Using these two consonant addiction models as a theoretical foundation for treatment planning, a multimodality approach to addiction treatment involves developing programs to assist the client in acquiring skills. These skills involve learning how to cope with stress on an affective, cognitive, and behavioral level (Milkman 1983).

Multimodality Treatment Modalities

Affective Modalities. Affective modalities are biopsychological and stimulate a state of altered consciousness. It is thought that altered consciousness results from changes in neural/neurochemical mechanisms in the brain brought about by increasing or decreasing neurotransmission (Milkman and Sunderwirth 1983). Neurotransmission is subject to stimulation or demotivation and appears to be controlled by endogenous chemicals. Addictions appear to alter consciousness by changing levels of neurotransmission. Levels of neurotransmission may be modified by environmental factors, that totality of physical and social phenomena which surround or affect an individual. Perceived threats to an individual's survival or perceived safety and security are some environmental perceptions which may alter an individual's levels of neurotranmission. The ability to alter consciousness is a defense mechanism used by vertebrates which augments the organism's evolutionary survival chances under circumstances in which a cold and correct environmental assessment might be sufficiently demoralizing to mean the difference between life and death (Frye 1984b, 1980a).

The goal of affective modalities is to train the client to achieve an affective experience which may alter consciousness and produce feeling, emotions, moods and temperament. Stress management training may be an appropriate modality for this purpose, and the training may involve a) visual imagery to produce cognitive calming, b) progressive relaxation to achieve a tension-relaxation contrast, c) verbal suggestions to achieve deep muscle relaxation, d) autogenic therapy promoting heaviness and warmth in extremities and calming of the autonomic nervous system, and e) automated systematic desensitization where the client imagines a hierarchy of anxiety- producing situations under conditions of physical relaxation with the goal of weakening the anxiety responses (Charlesworth and Dempsey 1982; Chaplin 1975).

Charismatic group therapy may be another affective modality which may alter consciousness (Galanter 1982; 1978). Often seen in drug-free TCs, Alcoholics Anonymous and religious groups, charismatic therapy may involve totemic objects and rituals with a behavior code. It is associated with a zealous movement and there is limited differentiation between the caregiver and the recipient. The group members adhere to a consensual belief system, sustain a high level of social cohesiveness, are strongly influenced by behavioral norms, and impute charismatic power to the group or its leadership (Frye 1981b; 1984). The altered states of consciousness produced by charismatic therapy appear to be similar to those seen in the religious conversion experience, and relief from depression and anxiety may be experienced by the charismatic group member (Galanter 1978).

Meditation is an affective modality associated with a decline in addictive behavior (Aron and Aron 1980). It usually consists of a sustained effort at thinking, usually of a contemplative variety. It may involve a mantra or sound pattern as an incantation. The physiological effects of meditation are opposite to those identified by medicine as being characteristic of the effort to meet the demands of stress (Selye 1975). Like drug-using behavior, meditation appears to alter the individual's perception of stressful situations and promotes behavior change toward objects and circumstances in the environment that are perceived to be threatening (Frye 1981a).

Alpha brain wave conditioning may be an adjunct affective modality in the treatment of addiction. A brain wave is the rhythmic fluctuation of voltage between parts of the brain. Clinical research has reported the correlation of alpha activity with subjective states of relaxation, peacefulness, etc. (Kamiya 1964). The purpose of alpha biofeedback training might be the production of a standard stimulus-response association between alpha control, and anxiety reduction and anxiety reduction need not derive from the biofeedback in order to become paired with it. Biofeedback may be useful at an early treatment stage, but later stages must lead to the development of styles of thought and behavior fostering autonomy from existential crutches (Goldberg, Greenwood and Taintor 1977).

The Experiential Group Marathon may be an existential affective modality that can stimulate a state of altered consciousness and consists of a group encounter of extended length, usually of 24 hours duration or more. At the end of a marathon, individuals often feel they have gone through a unique, singular experience that makes them special (Cohen and Rietma 1980). The individual may report a changes state of consciousness (a "peak" experience). Active mechanisms in the marathon promoting altered affect might include sleep deprivation, stimulus intensity (sound, light), shared group closeness or cohesion and emotional release (Hoag and Gissen 1984; Frye, Hammer and Burke 1981).

Ericksonian psychotherpay may be an affective modality of use in the treatment of addiction. This modality uses resistance, symptom prescription, paradoxical double binds and strategic interventions with complex embedded metaphors, hypnosis and strategic use of trance phenomena (Erickson 1980; Lankton and Lankton 1983). Neuro-Linguistic Programming (TM) is based on Ericksonian techniques and may solicit affective change or altered states of consciousness (Grinder and Bandler 1982).

Cognitive Modalities. Cognitive modalities include didactic lectures, seminars, workshops and audio-visual presentations. When individuals receive adequate training in certain skills such as assertiveness, socializing, sexual functioning, or value clarifying, they often change their thinking, behaving and emoting, and sometimes make themselves less emotionally disturbed (Ellis and Grieger 1977). Studies have appeared that have demonstrated that skill training has therapeutic effects, and such training includes an important cognitive element (Byrne 1973; Christensen 1974; Usher 1974).

Cognitive-Behavioral Therapy may be a modality of use in the multimodality approach to treatment for addiction, and it has proven useful as an alternative and adjunct to traditional approaches. This approach includes assumptions that treatment planning includes the critical element of evaluating how the client perceives the effects of addiction and how the client perceives the reasons for addiction. The treatment planning may then explore alternatives and challenge misconceptions. Specific targets of treatment are identified by the client and therapist so that progress can be objectively measured. A target is defined as a problem area that is related to the addictive behavior (Weiner and Fox 1982).

Rational Emotive Therapy (RET) is a Cognitive-Behavioral Therapy that assumes everything people do includes very important learning elements. Ellis (1977) wrote that biological inheritance and self and social learning tendencies combine to make us human and to provide us with our main goals and satisfactions. We largely control our own destinies and particularly our emotional destinies by the way we interpret or look at the events that occur in our lives and by the actions that are chosen to be taken. Rational Emotive Therapy has utilized therapy groups designed for impulsive individuals and has been used to treat addictive behavior (Watkins 1977).

Behavior Modalities. Among the techniques available to the behavioral therapist are anxiety-relief responses, assertive behavior facilitation, behavioral rehearsal, conditioned suppression, covert extinction, covert reinforcement, emotive imagery, implosive therapy, replication therapy, self-desensitizations, shame aversive therapy, thought stopping and time out from reinforcement (Chaplin 1975). Behavioral therapies have been utilized as treatment for addiction and applies learning principles and techniques. It assumes that disorders such as addiction are learned ways of behaving that are maladaptive and consequently can best be modified in more adaptive directions çthrough relearning. A direct attack is made on the client's symptoms.

Aversive therapy is a behaviroal modality aimed at reducing the frequency of maladaptive behavior by associating it with aversive stimuli during a conditioning procedure. The use of drugs (antabuse), electric shock or other aversive stimuli may become paired with the addictive behavior. The addictive behavior becomes aversive and the client develops a repugnance for that behavior. Electrical and chemical aversion techniques may be difficult to apply to the typical addicted individual. Covert conditioning or sensitization has gained some accucing the frequency of maladaptive behavior by associating it with aversive stimuli during a conditioning procedure. The use of drugs (antabuse), electric shock or other aversive stimuli may become paired with the addictive behavior. The addictive behavior becomes aversive and the client develops a repugnance for that behavior. Electrical and chemical aversion techniques may be difficult to apply to the typical addicted individual. Covert conditioning or sensitization has gained some acceptance in the treatment of persons addicted to drug using and consists of the use of imagined scenes as aversive events and as rewarding events (O'Brien and Lorenz 1979; Callner 1975; Cautela and Rosensteil 1975; Chaplin 1975).

Discussion

While it is probably not feasible in a therapeutic community to include all of the aforementioned therapeutic modalities, it may be worthwhile to include at least one modality from each of the three major classifications: cognitive, affective and behavioral. In the Ayrie TC, this includes stress management training, TC membership, experiential group marathons, seminars, workshops, Rational Emotive Therapy (RET), positive and negative behavior reinforcement, psychotherapy groups, confrontation-sensitivity groups, Vietnam delayed stress groups and contingency management. Addicted individuals comprise a wide range from various social classes, ethnic and geographical backgrounds, and no single program can meet the needs of all addicted persons. In recent years, a better understanding of the need for comprehensive, multimodality programs has evolved (Brill 1977). There is a need to focus on the individual as well as the addicted behavior.

Since polydrug, alcohol and other addictions permit individuals to cope by altering stressful environmental assessments and perceptions which may affect survival, successful treatment leading to cessation of that addictive behavior must consist of training in other, less destructive ways of coping.

As Tiger (1979: 173) has pointed out, humans, being more complicated animals, must have more instincts than others, and "our brains are higher brains, more efficient at diagnosing and ferreting out possible hazards, impediments, problems (moral and factual) and demons with which we can be harassed. It becomes all the more important then that we possess an overriding internal censor of all these mean and depressing thoughts so that we are not immobilized and disconsolate forever."

Addictions may activate the "overriding internal censor" by causing changes in neurotransmission promoting a feeling of well-being and optimism. Addicts may perceive environmental deficits which need to be filled by satiation; environmental excess which needs to be confronted by arousal; or environmental existential quiescence which needs to be altered by fantasy.

Treatment for addictive behavior may need to consist of a multimodality approach aimed at a) using cognitive and behavioral modalities to achieve abstinence from the behavior or modification of that behavior; b) using affective modalities to substitute other behaviors to help fill the void created by abstinence; and c) using cognitive, behavioral and affective modalities to provide skill training in altering consciousness to overcome perceived environmental impediments on a long-term basis.

According to long-term observations by this author, most if not all successful therapeutic community graduates have found substitutes to fill the void caused by abstinence from drugs including alcohol. These substitutes, or alternatives to taking drugs, involve techniques to alter consciousness -- to "get high" naturally. According to Weil and Rosen (1983; 170), "There is growing evidence that high states are crucial to well-being. People who learn to change their conscious experience in safe and positive ways seem to be the better for it. They are healthier physically and mentally, more creative and productive, contribute more to society, and are more fun to be around."

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WORKING WITH MINORITIES IN THE TC

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Let me begin by expressing my gratitude to the World Conference of Therapeutic Communities and to Walden House for inviting me to attend this conference, and for allowing me the opportunity of participating in this cross-cultural exchange of ideas. I would also like to give special recognition to Charles E. Dederich and the people of Synanon for having the courage of their respective convictions which, in my opinion, provided groundwork and structure for a majority of the therapeutic communities in existence today.

I feel a sense of kinship with all of you here, because although we may follow slightly different paths, the goal that we aspire to is essentially the same. I would generally describe this commonality of purpose as the creation of environments which encourage personal growth through psychological, social and political insight, support for behavioral change, and at its' very best, providing each individual with the opportunity for finally taking possession of his or her own life.

I would like to direct your attention to the issue of culture as it pertains to this relatively new therapeutic community movement. The mental health field has traditionally seemed to view culture as being either too complicated to deal with, or therapeutically unimportant. Now, it has long been a given that culture, with its many definitions, is vital in shaping our perceptions. Therefore, this resource, whether acknowledged or not, must play an integral part in any process that aspires to be of therapeutic value. It is this issue of culture and my concern for seeing it consistently included as a priority in the design of treatment programs in general that will be the focus of my attention during this presentation. My own experience has been working in a majority White culture with White, Black and Latino clients in the United States for approximately 17 years. I will present from this experience, but will encourage you to draw specific analogies and make appropriate applications as they pertain to the cultural representation of your respective communities and countries.

Most often in therapeutic communities, the concept of "Family" is a crucial and primary learning experience taught to incoming residents. The familial atmosphere is designed to provide a sense of warmth and belonging to those involved, making it possible for them to share more intimate details of their lives in a less threatening environment. It is easy to see the importance of this, because it encourages interaction early in the therapeutic process. By the creation of a family culture, we also facilitate control of the population by establishing fundamental behaviors and values that the entire family are required to accept and respect. This experience is not unlike the primary acculturation which occurs early in the development of each child and eventually shapes perceptions.

With this in mind, it is my opinion that culture is essential, not only in the development of each human being, but in the orientation of new residents in a therapeutic community as well. Of course, the cultural bias will favor the majority population represented in this "family"; staff and residents alike. However, this orientation is an extremely sensitive issue because the healing process takes place only in direct proportion to the resident's ability to adapt to the majority culture of the community. Consider for a moment, minority clients who must appear to disassociate themselves from their adaptive cultural perceptions in order to qualify for membership in this lifesaving system. This required assimilation, which necessitates a betrayal (either actual or contrived) of deeply rooted cultural values is, in my experience, destructive to the personal growth of minority group individuals. On the other hand, remaining loyal to cultural values and mores is most often misinterpreted and reacted to as resistance, the consequences of which are equally devastating, (i.e. increased insensitivity, alienation from the family, etc.). This double bind places the client in a situation where loss rather than gain is inevitable. A disclosing/non-disclosing duality has been created. This, unfortunately, is all too reminiscent of the institutional and systematic attempt by White people to belittle and obscure the rich cultural heritage of minority people in America.

This duality places the minority resident in a "no win" situation, especially when one considers the weakened state of any client seeking help from a treatment facility. The non-disclosing minority clients who are capable of pretending to disassociate themselves from their culture, have in fact merely relegated themselves to "gaming" through the system. This is true, even of those who appear to have become successfully assimilated into the family. If these non-disclosing clients are understood by the environment, they are considered insincere, and this insincerity will eventually become their undoing. If they are misunderstood, they will be considered model clients, and have to live with the guilt that arises from that deception. They in fact have short changed themselves, and traded comfortability for the illusion of status. This guilt, of course, like most guilt, is extremely hazardous to the client.

Conversely, the clients who select to disclose suffer because their world view is quite different from that of the majority population. When they speak of anger, frustration and suspicion, they will typically be accused of senseless hostility, naive expectations and paranoia, respectively. All of these are examples of deficit model interpretations of, what are in fact, healthy reactions to the majority culture world view. To be misunderstood in this way is predictable and familiar, although frustrating and painful to say the least. For minority group people to disclose and be understood is perhaps the most lethal of all possibilities, although it is typically seen as the ideal from a majority group perspective.

For example, when a Black client is asked to fully disclose to a White therapist even with the best of intentions, there is, in my experience, an almost unconscious counter-reaction which will inevitably leave the client feeling a sense of guilt and cultural betrayal once the disclosure has been made. This aspect of the cross-cultural trap is particularly complex. The client's fear of loss of control to a member of a society which he has learned to perceive as racist will exceed the boundaries of what is considered usual. This is exacerbated by history to the degree of suffering that this person has undergone solely by virtue of his ethnicity. He has in fact lost possession of his soul.

It is for these reasons, and others that I unfortunately do not have time to address today, that I feel that one of the most important priorities in the design of an effective therapeutic community must be consistent emphasis on the cultural and class aspects of the minority groups represented, or potentially represented, in that community.

My experience has taught me to be somewhat cautious in regards to presenting possible solutions for these problems to majority population therapists. Thomas and Sillen state in their book Racism and Psychiatry, that, "It is arrogantly ethnocentric to judge other cultures according to the degree to which they deviate from one's own". It is this arrogance, both conscious and unconscious, that makes any viable solving of these problems particularly difficult. The best minds in the academic community seem to address these issues by invoking the myth of "color blindness". Simply put, this approach seeks to render the impact of racism on a minority individual's personality as illegitimate and nonexistent concerns, which are overshadowed by psycho-social phenomena which the majority population view as central. Again, perception as it is shaped by culture is crucial here. Without becoming intimately involved in the rich and fascinating world of non-ordinary cultures, it is highly unlikely that majority population therapists will broaden their own cultural perceptions to a great enough degree to be able to understand, respect or effectively deal with minorities.

However, since nothing beats a try but a failure, I feel that the necessary commitment is clearly apparent. We must commit ourselves, Black, White, Green or Grizzly, to becoming truly multi-cultural in order to effectively serve our varied clientele. The bridge is to be willing to scrutinize our programs with an eye towards enhancement through a concern for culture as well as behavior modification. This step can lead from a philosophy of talking, and abstract rhetoric, to a philosophy of action. This action can take the form of searching outside of an incestuous, closed system for qualified, bi-cultural therapists who are capable of supporting a staff in broadening their individual cultural perceptions, and becoming sensitized through seminars, workshops and staff group interactions on a consistent basis. The degree to which this is possible will depend entirely on the strength of purpose and commitment of the individual therapists involved. I think that each of us can be fairly judged by the intensity of this commitment, because it is the responsibility of the therapist to be consistently involved in the process of growing and becoming. Do not make the mistake of confusing bi-cultural with simply being a member of a minority culture. If individuals are not sensitized to the special needs of any culture with which they come in contact, they have a responsibility to learn as much as they can about the differences. The similarities are self evident. If therapists are not willing to take this responsibility, they should, for the sake of integrity, step out of the way and allow those who are willing to take the responsibility share in this special privilege. By dealing with a clients cultural perspective, we can gain access to his psychological processes, and herein lies a resource which only the most dedicated should engage.

By this time I would hope that it is absolutely clear that only bi-cultural minority group workers should attempt facilitating the specialized arena of the minority therapeutic group. This, once again, is not simply a matter of skin color or ethnic background, but requires true cultural sensitivity. For example, to be a person of color in America does not automatically mean that this person is familiar with the basic assumptions or subtleties of meaning inherent in a culture. Therapeutic groups for Black minority clients, for instance, are most effective when the Black therapist is capable of collaborating individually and collectively with the clients. This is often the first time these clients have experienced disclosing their feelings in an atmosphere which seeks to dignify them.

When a staff is sensitized to cultural issues, and trust is established, as a side effect of dedication and commitment as demonstrated by hard work in the aforementioned seminars and workshops, only then is the stage set for comprehensive work with minority clients. In this way, minorities can be engaged, and rapport can be established at the very beginning of treatment. As you well know, the rapport can be transformed into trust, and in any therapeutic environment, trust is the key.

I would hope that nothing of what I have said here today has lead you to believe that I am trying to push majority populations away from dealing with minority populations. On the contrary, my intention has been to hopefully shed some light on an old and very sensitive and complex problem which, in my view, is crucial to the further growth of the therapeutic community movement. I am personally committed to what I have shared with you today, and I am at the service of anyone who shares this commitment.

THE GROUP PROCESS WITHIN THE CONTEXT OF THE TC

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This paper is a beginning in regard to conceptualizing the group process as it occurs in the context of the therapeutic community. It is concerned with identifying and examining at least some of the underlying dynamics that occur on different levels. It addresses the process as a safety valve mechanism, as a check authoritarianism, as a mirror, as projection, as the search for truth, as the assertion of self, as the discovery of personal power, and, finally, in the context of the game. It also considers who is ultimately responsible for the growth, or lack of growth, of our resident populations.

Any attempt to conceptualize an experience has an inherent flaw. It is an attempt to communicate on the level of rationality what was originally communicated on the level of experience. Although one can move from the level of rationality to the level of experience to produce an expansion of communication, moving in the opposite direction usually produces a constriction, unless there has first occurred a shared common experience. Hopefully, most of us attending this conference have shared experience of the group processes in the context of the therapeutic community. Therefore, it is hoped that this paper will produce an expansion of our communication.

You will notice that there are not voluminous references and footnotes. In preparing this paper, I tried to rely primarily on looking at, and coming from, my own experience, rather than relying on what others, who may or may not have had an experience with the group process, might have had to say about the subject. I realize, as I am stating this, that this will probably be interpreted by some mental health professional somewhere to illustrate that those of us in the TC movement really are an arrogant lot. I'll take the risk.

Historically, the process, as developed and evolved in the therapeutic community, came out of an essentially pragmatic approach, during which there was continuing feedback about whether it was working. There was a great deal of intuition involved in the early development of the group dynamic and little or no rational processing of how or why it seems to be valuable. Only in recent years has there been any intellectual processing of the experience. This paper is an attempt to move further in that direction.

I have been using the word process in the title of this paper and in the preceding paragraphs for a particular reason. I would like to take a few moments to discuss what I mean by process as distinct from content. The dictionary defines process as a systematic series of actions directed to some end. I think that what is important about a process is that it leads to a desired result or goal. Process is concerned with the system. The content refers to what the series of actions looks like in detail, that one takes to reach that goal. In this paper, my primary focus is on process rather than content. The content can vary in relation to personal incli-nations, cultural, ethnic, age, and educational considerations, and severity and nature of pathology of the residents served. Process is primary. Content is secondary to process.

The proliferation of therapeutic communities world-wide over the years has created a wide spectrum of "contents". Various "therapeutic tools" may have a different appearance from T.C. to T.C. but, hopefully, what unites us all is a common process leading to some common goals - the empowering of our residents and, coincidentally, ourselves, by changing self-destructive thinking and behavior patterns, teaching personal responsibility, changing negative self-image, creating a sense of human community, and providing an environment in which human beings can grow and take responsibility and credit for that growth.

I suppose that, at this point, I should take a stab at describing what it is that I mean by "the group process," so that we can assume that we are talking about the same thing. The group process has been called many things, including "a synanon," "a game," "an encounter group," "a T-group," etc., etc. what I mean by "group process" is a leaderless group that usually occurs several times a week in the context of the therapeutic community. To say it is leaderless is not to say that there should be no officially designated leaders, as this usually results in the group process serving the egos of the designated group leaders rather than serving the residents as it was originally intended. Leadership emerges in a natural manner and will also be passed back and forth. In such a group, anything goes except acts or threats of physical violence. There is freedom to express one's feelings and thoughts. All members have equal rights in such a group--there is only personal status. One cannot use or hide behind vested status. If you are an authority figure, you do not get to wear your "hat," or title if you will, in the group setting. You assume the leadership of the group as a function of your capacity to lead, not as a consequence of your "label" or position in the community hierarchy. This means that everyone is a participant. No one gets to exempt himself or herself from the process.

On the designated days (usually three times per week), the "Group-Master" or "Guru" would break down the entire population of that facility ("staff" included) into encounter groups of 8-10 individuals. These groups were not open-ended. They had a time-frame to operate within, usually one and one-half hours. The Guru organized the composition of these groups with certain considerations in mind. Generally, his or her first consideration was to honor any "slips" that had been dropped by residents. A "slip" was simply a piece of paper with two or more names on it. It was a device for requesting to be placed into a group with certain other individuals, usually in order to confront those individuals about some piece of behavior or attitude. The Guru then worked toward making each group a cross section of the resident population in regard to chronological age, sex, ethnicity, racial background and age in the T.C. Each group had several older (age in T.C.) and responsible members of the community. This was called providing "strength" in the group. These older and more responsible members were not officially designated as group leaders, although they may have been staff members. The "strength" in the various groups were, generally, briefed on what "slips" had been honored in their respective groups by the Guru, so as to insure that these confrontations were facilitated. These groups did not have a static on-going membership. The composition of these groups changed from group meeting to group meeting. Over time, every resident and staff member was afforded the opportunity to interact with and receive feedback from every member of the T.C. in that particular facility in a very direct and ritualized manner. The basic therapeutic approach in these groups was personal confrontation.

I realize that this confrontational approach, over the years, has been as passionately condemned as it has been supported. Without becoming involved in an extensive debate in this regard, I would like to make a couple of points about the confrontational approach. First of all, confrontation, like any therapeutic tool, must be wielded with good judgment in relation to the nature and type of population being served. Secondly, this confrontational approach needs to occur in a context of respect, caring, nurturing and support - lots of support. Context is everything.

When I began to examine the group process, I was struck by the complexity of the process itself. There are various dynamics occurring on various levels. It is akin to peeling away the layers of an onion. The purpose of this paper is to identify and begin, at least, to conceptualize some dynamics that occur at different levels, so as to open a dialogue rather than to make someone else wrong.

The Process as a Safety Valve

As most of us well know, living within a therapeutic community setting is an intense experience. It is designed to be. In addition, it is structured to make it extremely difficult to escape from that very intensity. There is virtually no refuge short of leaving the community. As a new member of the community begins to experience the intensity inherent in living and working in a highly structured and demanding community, feelings of frustration, anger and hostility surface rapidly. Make no mistake: this is intentional.

As Charles Hampden-Turner so aptly points out in his book Sane Asylum, describing the Delancy Street Community.

> The strict regimen, the confusion, the hard menial work of the early weeks are deliberately designed to precipitate explosive Games. The sooner someone's genuine anger and emotion have been registered and recognized, the easier it is to deal with the incredible tangle of lies and self-delusion with which newcomers strangle themselves. Residents cannot begin to deal with each other's problems unless the habit of authentic externalization is quickly established.
>
> The roars of rage are also, perhaps, the only possible introduction to the world of feeling. As residents develop, they are able to express many different feelings of great range and sensitivity. But for the newcomer, and especially for the male newcomer with his macho image, anger is the only acceptable feeling and it serves as an outrider for all the rest.

Now that we have caused these rather strong and intense feelings and emotions to surface, we must provide a way for them to be handled. Since the expression and acting out of this anger and hostility in the normal course of getting the job done in the T.C. is strictly proscribed, for obvious reasons, it is imperative to provide an arena for these feelings to be expressed in a manner in which no one is truly harmed. The group process functions here on the level of safety valve. It is an appropriate and safe arena for the "blowing off" of hostility, anger and frustration. It is a ritualized and essentially harmless form of verbal violence as an alternative to physical violence is no small matter, considering that many of our residents have long histories of physical violence and abuse.

In the process of waiting to handle one's feelings in the appropriate arena, the resident begins to learn about delaying gratification and exercising self-control.

The Process as a Check on Authoritarianism

We have all heard the assertion that power corrupts. Power tends to corrupt when it only flows downward from its source. The group process provides and supports the opportunity and vehicle for power to flow upward from its objects, specifically the individuals most affected by that power.

The group process can provide very direct feedback to those individuals in authority concerning their performance and the effect their exercise of authority has on those they supervise. The abuse of authority or power is extremely difficult to hide in a community that provides a mechanism for magnifying and closely examining abuses. Since individuals in authority are prohibited from wearing their "hats" in a group, an individual's status in the work or job hierarchy means little or nothing in the group setting. Authority figures are further prohibited from seeking any sort of revenge outside the group setting for something that might have occurred within the group process. The group setting allows authority to be challenged and checked without destroying it in the process.

The Process as a Mirror

Every time an individual participates in the group process, he is afforded a special opportunity, whether he wants it or not, to see himself from as many different vantage points as there are other participants in the group. One almost literally can see oneself through the eyes of others. There is a very direct and intense feedback about how you present yourself which is extremely difficult to evade. Every detail of your life and how you handle it is under the closest scrutiny in a T.C. What makes it especially powerful is that this feedback comes from significant others, i.e., the individuals who one lives and works with.

Walter Kerr, renowned drama critic for the New York Times, in his review of the play The Concept created by residents of Daytop Villiage, shows a great deal of perception in writing about the process: "... the people on stage have long since taken themselves out of themselves for a good look, held themselves up like art objects to be examined objectively, dispassionately. They have recognized themselves by taking one giant, wrenching step backward from their earlier adopted skins, from their postures, their rationalizations, their habits, their self-portraits. A bold degree of detachment came into being while they were curing themselves; it was the principal thing that cured them."

The Process as Projection

Most of us are familiar with the concept of projection and its important role in the group process as we know it. What I mean by projection is the ascribing to others the feelings, attitudes, desires, and thoughts we have or have not identified in ourselves. Since the individuals assuming the leadership of the group process at any given time are not traditionally educated professionals, they have a distinct tendency not to operate from intellectual constructs about what is occurring with the other person. Insights about what is going on with the other or what the other needs at any given time come out of their considerable ability to empathize and take the role of the other. They come from their personal experience. On the level of projection, knowing the other is a function of knowing oneself. The one gaining the deepest personal insights from this projection interaction is the one doing the projecting.

As Dr. Lewis Yablonsky wrote in his article, On the Anti-Criminal Society: Synanon, in the September, 1962, issue of Federal Probation, "The group sessions do not have any official leader. They are autonomous; however, leaders emerge in each session in a natural fashion. The emergent leader tells much about himself in his questioning of another." Chuck Dederich, in his paper Synanon Foundation, appreciated and understood the importance of projection: "By virtue of an empathy which seems to exist between addictive personalities, they are able to detect each other's conscious or unconscious attempts to evade the truth about themselves.

The temporary leader leans heavily on his own insight into his own problems of personality in trying to help the members to find themselves, and will use the weapons of ridicule, cross-examination, hostile attack, as he feels inclined. The temporary inquisitor does not try to convey to the other members that he himself is a stable personality. In fact, it may very well be that the destructive drives of the recovered or recovering addictive personality make him a good therapeutic tool--fighting fire with fire."

The Process as the Search for Truth

Many of us have heard of truth in lending. What I want to address here is truth in feeling. The process as the search for truth is about absolute honesty in regard to feelings. No compromises are accepted.

It seems that one by-product of the socialization process in the western culture is a shift away from directly experiencing feelings to a rationalizing of feelings, so that they are filtered and censored before they are expressed or communicated. Often when you ask someone how he feels, what you get is his thinking about how he thinks that he should feel. Somewhere in this complex process, we lost the ability to tell the truth about, and connect with, how we feel. For most people, this incongruity, this lack of connection to feelings, does not seem to create a serious problem, although the price paid is probably as dear as it is subtle. For the people who seek us out, it seems to play a part in or contribute to their drive towards self-destructive behavior.

If one looks for truth in the group process regarding the facts and specifics of incident, one will look in vain. There are here and there one or two facts but the details of an incident are usually exaggerated to bigger-than-life proportions, which makes it difficult to tiptoe around them or to act as if one does not understand them or to pretend that one missed them somehow. What one can count on being true in a group, however, are the feelings. It is also an arena that asserts the validity of one's feelings within a larger culture that continuously invalidates one's feelings and ultimately, one's humanity.

The process on the level of the search for truth is about saying the unsayable, speaking the unspeakable. For many, it may well be the beginning of bringing to the surface material from the unconscious that could not be expressed elsewhere. Walter Kerr, in his review of the The Concept, made an interesting and insightful observation about the group process: "Encounter (is) a group session in which the participants fiercely and deliberately attack one another not for their failings but for their lies about their failings. . ."

The Process as the Assertion of Self

If we take the time to look at it, we will notice that most of our residents come to us stuck in their fear about their own insignificance. It is the secret that they fear that the rest of us will discover. Charles Hampden-Turner's Sane Asylum paraphrases Mimi Silbert on this point:

> " . . . Most residents in their early months are, in fact, consumed by self hatred." Although sociopaths are often said to be conscienceless, Mimi Silbert contends that their guilt is, in reality, as strong as it is deeply repressed. The volcanic eruptions within the Games help to spew the guilt forth, while the name calling actually makes contact with the image that the individual has of himself in a way that the soothing assurances of most professionals can never do.

The group process then becomes the vehicle by which the new resident can begin to externalize the anger, hostility, and hatred that he previously directed towards himself. In the process of confronting or attacking another effectively with the group setting, one has to shift from being nobody to being somebody. One cannot deserve to feel angry unless one is somebody. As the resident develops and begins to assume some leadership in the group, he must begin to embody the role of leader, teacher, therapist, wisdom incarnate, and, in general, role model. One cannot do this from a position of nothingness. According to a Synanon brochure, "Synanon Games are fast paced and exciting, with frequent wild accusations, screams of rage, and peals of laughter. Each person's decision to involve himself in a fight for his own self-image and dignity demonstrates the sportsmanship necessary to the Game."

The Process as the Discovery of Personal Power

The process on the level of personal power is concerned with responsibility. Generally speaking, our resident population has demonstrated a great capacity for dishonesty with themselves and with others in regard to personal responsibility. Consequently, they have been able to take refuge in their own powerlessness. They seem to experience life as a series of things that just happen to them and which have no relationship to them as actors.

In the group process the emphasis is on the here and now. The group participants are not really interested in the "whys," but rather what one is going to do about them. The "whys" are usually used to externalize the responsibility for how one got where one is and, as such, are not acceptable. What is demanded is the telling of the truth about who is responsible. The choice to accept responsibility for how one got into this mess in the first place is the beginning of the realization of one's power. The next step is to realize experientially that one is powerful (responsible) for where one will be next.

The Process as a Game

The group process should also operate on the level of a game. I mean to advocate such a context. Operating out of a context of the game has some definite and beneficial consequences. It serves to increase and expand the sense of a safe space. In the context of a game, there is a lessening of the fear or anxiety that one can truly be hurt or destroyed. After all, it is only a game! On the level of game one can more readily begin to learn to "play with" strong and intense feelings and emotions instead of being overwhelmed by them. It becomes less threatening to begin to tell the truth about oneself to oneself. It is easier for one to begin to try new roles as well as new and different ways of being. Finally, on the level of the game, there is a potential for detachment about who one really is that ordinarily would not exist.

It used to bother me slightly that in some circles the group process is and has been referred to as a game. There was something irreverent there which made me uncomfortable. After all, we are dealing with people's lives, we are dealing with treating people, we are dealing with people getting better, recovering, growing, etc. This is all very serious business, or is it? There is the danger in all this seriousness that we will begin to take ourselves too seriously, so seriously that we might begin to believe that it is we who are responsible for the residents' growth, that somehow we caused them to grow in spite of themselves. Nothing could be more dangerous or demeaning to our populations and, ultimately, to ourselves. If we're lucky and we work real hard, we can create the climate in which individuals choose to grow and become responsible for their own growth. The context of the game would definitely be appropriate in reminding us to lighten up.

Some may consider this effort a back-looking journey into our past and I suppose that in many respects it is just that. I happen to believe that it is essential to understand and appreciate where we came from in order to move forward in a way that we don't become lost in whatever the current, continually changing, rhetoric and fads happen to be. In order to avoid this trap, I maintain that we must better understand what is valuable and, what is not, in the roots from which the T.C. movement has grown. The roots that set it apart from more traditional approaches to residential treatment.

I am not opposed to change and exploration of new possibilities. My concern is that in our desire to be recognized and accepted by the larger mental health professional community, we end up settling for style rather than substance. Some of us never really understood and appreciated the substance, but rather only learned the style and thought that we had gotten all there was to get. A good understanding of the process, its uniqueness, substantive value and how it works, frees us to build on it, to change it without destroying its value and to have fun playing with the content. It is my hope that this paper has contributed in some small way to further expanding our understanding of one element of this process and to stimulating more dialogue.

I believe that what sets the T.C. approach apart from other therapeutic approaches, namely, the "medical model," is a process that is about empowering people rather than diminishing them. It is difficult, if not virtually impossible, to be empowered while being forced to play the role of "patient." In the T.C. process, we have managed to bridge the dichotomy between the therapist and patient, "teacher" and the "student." The process is at its best, when the "teacher" is also the "student" and the student is also the teacher and that the teacher models what he or she is attempting to teach..

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ADDICT RAGE - A THERAPEUTIC DILEMMA

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Once Abraham Maslow paid a visit to Daytop Village, a therapeutic community located in New York City. He commented: "The process here basically poses the question of what people need universally. It seems to me that there is a fair amount of evidence that the things people need as basic human beings are few in number. It is not very complicated. They need a feeling of pro-tection and safety, to be taken care of when they are young so they feel safe. Second, they need a feeling of family, clan or group, or some thing they feel they belong to by right. Third, they have to believe people have affection for them, that they are worth being loved. And that's about it ... could it be that Daytop is effective because it provides an environment where these feelings are possible? (Maslow, 1971).

Individuals arriving for treatment at therapeutic communities arrive through a variety of referral sources. Whether directed by the courts, probation or parole departments, social service agencies, churches or families, they all have "bottomed out." That is, they have exhausted all their means of supporting their compulsive drug taking and are now in need of treatment. They are usually full of remorse and emphasize the negative aspects of their addictions. However, after the detoxification phase is completed and early attempts at therapy have begun, the residents recall their addictions with a more romantic flair, conveniently forgetting the dysphoric aspects of their compulsions. (Marin, et.al. 1976)

The therapeutic community will provide (as described so well by Maslow) an environment that encourages responsibility, honesty, and integrity, with a clearly defined structure that will nurture and care for the resident in a way which will precipitate the deep and always painful exploration into the factors that contributed to the development of a compulsion to use drugs regardless of the dire consequences which too oftentimes include death. The therapeutic community will provide, perhaps for the first time in the drug user's life, a person who will empathize, encourage, validate, confront, limit set, and generally provide an emotional climate that will help the drug user to explore his/her psychological workings in order to provide a roadmap that the addict can use, not soley to "straighten out," but as a future guide to a full and productive life.

Yet, a certain impasse oftentimes develops between the new resident, the community, and her/his counselor. His/her view of the world is tainted with shades of mistrust. The world had been a hostile, unforgiving place where one took what one wanted. Nobody had ever given him/her anything without motive. Deep down she/he is very angry at these circumstances, and this anger can permeate the individual's total therapeutic community experience in a negative way. It sets him/her aside from her/his peers. He/she becomes the community scapegoat and group's object of focus and frustration. The compulsive drug user rejects the care and concern of the community and moreover blames the collective for its shortcomings as the reason for his/her state.

The most unfortunate consequence of this behavior is the strong negative feelings that result within the therapeutic relationship. The counselor is caught in an angry countertransference brought on by his/her feelings of helplessness and defeat.

Why, one might wonder, should an individual who is welcomed into the family of a therapeutic community act in such a manner as to reject the very milieu that is the prerequisite of her/his recovery? The answer to this and other questions related to the drug abuser's behavior is that the drug user has, due to his/her limited experience, a very limited number of options to choose from. In essence the way she/he acts is the only way he/she knows how to act. The behavior has become a defensive adaptation that is woven into the personality.

The drug has subsituted for the intimacy of relationship so the when the individual must maintain intimate relationships within the open structure of the therapeutic community she/he responds with a complex set of defenses and affects that have little or nothing to do with the current circumstance. Wurmser (1974) claims that drugs create within the inner life of the user an artificial or surrogate defense against overwhelming feelings. Thus, thinking has begun to change. Instead of drugs being an escape from reality, they are used by the abuser as a costly adaptation to the stresses of reality. It is, in essence, an attempt at self medication and should be viewed as such, without judgment of condemnation.

It is beyond the scope of this paper to begin to explore recent writings in the literature about narcissistic and borderline pathologies and their relationship to the treatment of compulsive drug use. However, it is important to realize that the drug has become for the individual user the lost object which should have provided the physical and emotional stability for a normal, healthy maturation. The loss leaves the individual with a strong rage reaction, usually blocked with significant depression and defended with a series of primitive defenses. If the individual addict allows her/himself to really feel the care and concern of his/her counselor and peers, then the devastation of the object loss would be complete and undeniable.

Once the counselor understands that she/he is operating within the transference field, then the behavior becomes understandable and open to a variety of therapeutic interventions. As mentioned, the compulsive drug user views the world as alien and hostile, making it difficult to trust, especially with the vulnerable feelings related to the repressed rage of the object loss. The counselor then must become for the drug user a "model" -- someone he/she can idealize, respect and trust. The counselor must be consistent, genuinely interested and concerned with the recovery of the abuser, and demonstrate the important combination of care and limit setting. As the therapeutic relationship develops there will be numerous situations which trigger primary process rage reactions. For example, a denied pass, an unwelcome job or bed change, disagreement with peers, and especially conflict with "authority figures" can be used to work toward discharges of primary rage. First the here and now anger should be explored and discharged. These scenarios should never be viewed as games but rather as conduits leading to primary process issues.

Therapists and counselors unfamiliar with the depth and breadth of the feelings involved with this level of discharge would be well advised to seek out and work on these issues themselves in order to avoid the possibility of "rescuing" the client from these pains via avoidance.

There are various techniques that may be used individually or in tandem to help the drug abuser discharge these strong affective states. Djalaji (1978) found Bioenergetic Therapy helped reduce anxiety and lift depression for drug abusers when compared to those who received only talk therapy. The use of psychodrama has proved an effective tool to help individuals release long repressed emotions. The method is less important than the level of competence and understanding of the practitioner. It is during these sessions that the therapeutic alliance is well developed. After these discharges clients are quite vulnerable and open. It is at this time that the counselor provides the corrective emotional experience for the client, allowing she/he to grieve for his/her lost object. The occurs while providing the structure and safety to begin the formation of a self that can tolerate these affective states without the auxiliary ego called drugs. Thus the rage is used to help her/him become vulnerable and experience that state without being hurt, humiliated, subjected to abuse.

The result on the individual is immediate and apparent. There exists a congruency between words and deeds that did not exist before. The depression that was pervasive begins to lift and the individual begins to take a more responsible role within the structure of the community. One notices their participation in group to be more of a personal sharing than a pontificating. Most important, the individual realizes just how important the drugs were to him/her as a self administered medication. Once this level of awareness is reached the individual is on the road to life long exploration.

Working with the primary rage of these clients is no panacea, and must be integrated into a treatment milieu that includes vocational and educational development, family treatment, and an overall structure that increases responsibility. Thus the addict rage is converted from a ticket back to the destructive life style to an opening up to the strong possibility of a fruitful, productive life.

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LEAVING THE TC: FANTASIES & EMOTIONS

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Disturbances in the Process of Separation-individuation

I think that what our psychotic residents show us are the disturbances in a certain phase of normal psychological development. The normal development has not happened due to several complicated reasons, the affective atmosphere prevailing at home, and the singular characteristics of the child in question. Inside this intricate matrix where many histories and different related factors meet, is where the conditions for a normal transit through each moment of development takes place - or not.

When, due to different reasons, any component in that matrix is altered in the critical moments of development, a deviation occurs, and more or less serious consequences will inevitably appear through the whole vital cycle of the person. By "critical moment" I mean the one which, necessarily and in a substantial way, is basic to the fulfillment of a determinate function such as support, idealization, etc.

Using a metaphor, we conceive the psychological development as a train that starts from a definite point and has a destination. Along its way, the train goes over determinate stations at determined times. It doesn't stop except at those stations and times. It remains at each stop for a certain period and then continues its way until its final destination is reached.

The phase that M. Mahler (1984) and collaborators described as separation-individuation is one of these stations: a critical moment in the human child's development.

Our residents belong to those people who lost the train, or else they figure it never passed near them, or that it just passes them by whenever they want to board. The fact is, that they are at a disadvantage with respect to those who took the train at the proper moment and station. Their work in the TC consists in giving them an occasion to return to the main route, and board the train, although certainly with delay.

Case Histories from the TC: Juan and Anastasia

Juan, age 21, single, communicated to us on one occasion, "In a couple of months I'm going to continue high school and I won't be able to come here any more." A little later he says that he was going to propose a meeting in order to consider how to organize the Year's End party three months from now. I pointed out to him that he had said that he wouldn't remain in our center more than two months, and that the party would take place in three months, at the time when he, supposedly, would not be there. Couldn't that be a way to avoid speaking of his announced separation of the institutional protection?

Juan showed both astonishment and fury. "So, you are going to throw me away soon" he said. "You don't want me to keep on coming here, do you?" We told him that, on one hand he wants to go, but that he also feels a strong impulse to stay with us. So he thinks - with rage - that we want to get rid of him. We considered that it would be important to examine his idea of our trying to expel him instead of thinking he is the one who wants to leave.

One day, Anastasia, age 19, single, commented in her therapy group, "I won't be coming here any more starting next week because I've got a job in a factory." She silently observed each member of the group to see their reactions. "Of course, it is not certain, but I'm sure that I'll be back in a week" she added. There was silence. She continued, "It always happens so. After working some time I get bored and they take me to the madhouse. I stay there some time and they send me again to this place."

When the day of her announced leaving arrived, she was in an ambiguous state of mind as to leave or to stay. We let her know that it is not easy for her to tell us "good bye" and that she prefers to say, "see you later." Anastasia looked at us and uttered th following as a challenge, "Why do you want to keep me back?"

These two vignettes state a rather common situation when we are working through the separation anxiety with our residents. Underlying the process is the meaning that leaving is an "expulsion" or else "a way out to the inside." A proper analysis of this facilitates the transit through the phase of separation-individuation. In the exploration of this situation we verified that the prevailing emotion is not depression but rage.

As we worked with Juan on his idea of being expelled, he remembered some situations; for example, the fact that each time he expressed a personal desire his parents said to him, "It is nonsense, a craziness." At that moment he exploded, "I was born by mistake! My parents didn't want to have more children. Therefore I always am looking for a place to be." At the time when Juan arrived in the TC, taken by his parents, he said to them, "I don't want to come here. ¿I'm not crazy. Why cannot I be at home with you?" During the time he stayed with us, we learned that this meant, to him, "being thrown into a rubbish basket."

Let's return to Anastasia now. Her family situation was as follows: She was the first daughter of her parents who separated when she was three. She went to live with her father's parents. Both of her parents remarried. The father's family, which had a certain social reknown took charge of her. "Her parents left her", says the grandfather. According to the grandfather, Anastasia's mother "left home to live with a man, with whom she was madly in love." The 'love story' seems to have lasted hardly three months, and that, afterwards, she become promiscuous for some time until three years before the entrance of Anastasia to the TC, when the mother remarried and had a child. The most shocking component in Anastasia when we met her was an initial attraction and contact which soon was darkened by her hostility and negativism that caused rejection in all of us. One member of our staff said, "Half an hour after listening to her I wanted to kill her, to break her into little pieces! I couldn't stand her any more!"

Anastasia defamed her mother in group therapy calling her "crazy" and a "whore", but she adopted a fascinating submissive attitude every time her other came to visit. "Anastasia seems to be another person when she's with her mother" said everybody. When the mother spoke with us she oscillated between self-justification of her behavior and a massive attack against her daughter, whom she considered responsible for her present problems with her husband and eight month old baby.

Anastasia's father came only once, coming on Anastasia's therapist's request. He said that he does everything he could for his ç daughter, but he had a new family who he also had to take care of. He welcomed Anastasia in his house whenever she wanted to visit. Their relations were cordial; everybody accepted her (Anastasia confirmed this) but soon she wanted to be the center of attention in the house, fought with her half-brothers and reproached her father for not loving her. Then she would leave, but always returned soon and repeated the same situation over and over again.

Anastasia's mother informed us that "She comes home, stays some days very well, is always fluttering around me, takes care of her brother, but she finally makes a mess, provokes my husband and I finally ask her to leave. I can't stand her any more." The mother also said that after a couple of months Anastasia returns to repeat the same situation.

At her grandparents house on her father's side, the situation was more or less the same. Anastasia insulted them constantly. She called them "softened, retrogressive elders" each time they intended to put a limit to her rambles and promiscuity. In the TC she liked to tell, in a festive tone, detail by detail, her multiple sexual adventures.

We would like to remark that any time Anastasia left home she felt rejected, by the mother, father and grandparents. The separation never had a definitive character. She always left having the intention of coming back. It was a "way out to the inside" a compulsion to repeat a sadomasochistic bond with those people who were performing parenting functions.

In Juan's case the expulsion meant an explosive dejection. As to Anastasia, it meant a return through the way out. Her speech was ç"dirty." Soon after her announcement of leaving she said, "So you throw me away as if I was shit." So she returned to the TC in the form of a fecal penis to disorganize the group and the TC. She became explosive, manic, maddening to the extent that her absences were felt with a great alleviation by the other residents.

Anality and Domination: Its Relation with Narcissism

In order to articulate the clinical experience with psychoanalytic theory, we may say that the expulsion is bound with oral (to spit) and anal (violent dejection, flatus) sadism. Melanie Klein would say that it relates to an envious attack on the pregnant mother or parental couple made with excrement and flatulence. This attack bears, on one hand, the pleasure of the discharge, and, on the other hand, the fear of having this aggression turned against oneself.

Juan, before his leaving, remarked that he nowhere else received all the attention that was offered to him in the TC, but for a while the institution was no longer useful for him. The food was "nasty", the people were "dirty", and it was as easy as leaving a trash basket. Separating from the institution was how Juan recovered his own value. If a child gives to his mother what she appreciates (excrement), the child will be appreciated by the mother. Merged into his mother's desire, Juan tries to recover his self-respect; he isn't any more a "nastiness." But this is a destructive union, where value makes room for a mutual "burst." His drama is then to "be someone special, a genius (megalomaniac phase) or else to "be nothing, nobody." His anxiety due to the impossibility of "being someone" separated from his mother, without blowing her up or himself, was evident at the moment when his mother was going to be operated on when he said, "What is çgoing to happen with me if my mother dies, she's all that I have!" It is clear that he had others family members to take care of him: father, brothers and his older sister.

Starting from sphincter control, the child's increasing dominion over his body and its functions configures his feeling of self, the consciousness of his own abilities, his own self-respect and self-appreciation, which are the nucleus of the "narcissistic sector of the psyche."

It is in this moment of psychological development when "anality", through the domination impulse, becomes a structural part of the personality. In Three Essays on Sexual Theory, Freud (1905), said that it is "not originally a sexual impulse, and, that it only secondarily can join the sexual impulse" in order to explain "the infantile cruelty that seems not to take into account the other's suffering." It deals with the human being's tendency to master something. It's an impulse in the service of self-affirmation and growth. The domination impulse is the implement that the ego uses to transform the archaic infantile narcissism into a mature product regulated by the reality principle.

The relationship of the child with his bodily products, and through them, with his mother, is a narcissistic relationship. A disproportionate rejection of the child's bodily products frustrates the child, adversely affecting his self-respect, e.g. "You are a shit" or "All that you do is shit." If the child's bodily products are libidinally invested by the significant adults in the environment, this increases the self-respect, the internal cohesion, the self-identity, and opens the way for the sublimation of this archaic and narcissistic domination impulse.

Rage: The Predominant Emotion

We saw that both Juan and Anastasia got angry when they considered leaving the TC. Leaving was experienced as a narcissistic wound, a projection of their own unappreciation of the therapist staff. The frustration, proper to the psychological developmental phase, of their narcissistic need of being loved and appreciated by the object (the therapists as parental figures) forced them to develop a chronic rage. This way they became hypersensitive to any therapist's slight which was experienced as a personal rejection. Heinz Kohut (1978) states on this subject, "The mere fact that the other person is independent or different is experienced as offensive by those with intense narcissistic needs."

Based on our clinical material we are able to affirm that "narcissistic rage" emerges as a dominant emotion when the subject feels frustrated in his domination impulse. If his is a child this occurs any time when his infantile omnipotence is attacked. If his is an adult who has reached certain transformation of the archaic impulse, this occurs any time he feels he is losing control over situations where he felt self-confident.

The narcissistic fury is a distintegrative regressive product of the mature and self-affirmative aggression in a clinically healthy person. It appears like the available answer in those who are vulnerable when receiving personal censure since they need an external support to feel worthy and alive.

Conclusions

Our examples regarding leaving the TC served us to articulate the çclinical experience with the theoretical explanations of it according to psychoanalytic concepts. This way we examined the role played by the anal period of development, with its domination impulse, in the constitution of the narcissistic sector of the psyche and during the separation-individuation process. When this process is altered by diverse circumstances, the predominant emotion is rage.

Juan felt himself to be a "nastiness" expelled by his mother during childbirth, as an expression of her unconscious desire to get rid of him. His leaving from the TC regressively mobilized an archaic situation accompanied by an intense disorganizing rage. As for Anastasia, she seemed to re-create a proto-fantasy, which Freud called "intra-uterine life." Birth, followed by separation and progressive autonomy meant an "expulsion from paradise." To emerge from the womb meant losing the "oceanic feeling" and pleasure of symbiotic union. The movement of "way out to the inside" is an expression of this situation.

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THE ROLE OF ART AS A THERAPEUTIC TOOL

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I would like to explain to you what we are going to attempt to do with this "art" program. More important is for you to understand what we are not trying to do, and you will see how the two extremes will hopefully meet in the middle and accomplish what now seems abstract or foreign to the people participating and become a visual reality. When we talk about art we tend to think of a beautifully realistic painting, aesthetically pleasing to the eye and, uncomplicated, easy to understand, i.e., a painting, trees, flowers, houses, water, things we look at and see all the time. Familiar things. We are going to use the tools of different art forms to put into visual works those feelings we all have inside of us. The ones we don't have pictures for, or even words. Nevertheless, they are there. The famous artist of the 40's - 50's, Jackson Pollack, was a very sensitive, highly introspective man. He had many feelings that he needed a release for. His canvasses were always stretched out on the floor so that he could get down close to his work and feel he was a part of it. He proceeded to splash out, drip, push paint all over the canvas. When Pollack was upset, or feeling sad or feeling good, he would go into his studio, put those feelings, the ones he nor anyone else could reach, and put them down on canvas in his own special way. His works, a product of his feelings. No one can copy a Jackson Pollack. We are going to attempt to reach those feelings, the ones that make each of us, different from the guy next door. Kids coming into this program may seem a bit baffled at first. But once they begin to understand that they aren't expected to become "painters", but to use the medium as a form of showing their feelings they will see that color can be representative of feelings, also shape and the use of clay, collage materials, etc. A very useful tool to be able to have available.

A young boy flipped out from dust. He went into a program, but spent many months unable to be reached. He was arrogant, refused to socialize or talk with therapists. But he spent a lot of time "making things". He made an ashtray out of clay, a very deep one. Out of the center came the pieces that would hold a cigarette, long necked, round on top, staggering, leaning, different sizes, painted black. A kind of chaotic looking piece. One day his doctor saw it and asked him what it was. "Just an ashtray I made" was the boy's reply. The doctor said it looked like more than just an ashtray to her and that all things one makes have a meaning. Together they retraced the steps leading up to the day the boy made the ashtray. They found that it had been a very frustrating, confusing, painful day for him. It was the first day his parents and brother and sister came to visit him and his family did not handle it well, Nor did he. It's easy to see that all the pieces coming up in different directions leaning, some lower, some higher, were representative of the boy's family. The black ashtray was telling the story what the boy felt and saw and experienced that day, the feelings he couldn't tell anyone about, but without even knowing it, became crystal clear in "just an ashtray". The boy began to open up and talk about his family, eventually completing the program. It isn't "the" answer, but it is a helping hand, a different kind, but one to definitely be considered and included in a host of therapeutic tools.

TOWARDS AN ETHICS OF THE TC MODEL IN THE APPROACH TO THE ADDICTED PATIENT

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"I am a Man, I consider no other man a stranger.".
–Miguel de Unamuno

In this paper I will consider those aspects that account for the characteristics of the ethics of the TC model in the approach to the addicted patient, without entering into an analysis of the pathological features of the personality of these patients, nor abounding in explanations on specific working techniques in the TC.

I point out that, in the exploration of the structure latent in the human condition, I think of scientific work as a dialectical search between the territory still unknown, and its contrast with human reality, as a presence and a convoking power, in our daily effort. I am aware of the fact that "as different beliefs are not always explicit and expressed, he who thinks and creates on the basis of such beliefs, makes them apparent in the context of the system where they articulate with each other" (l).

The TC has a goal that is common to its members and a specific organization which operates as a whole towards the objective of combi- ning mechanisms which will allow it to perform its corrective and structuring task. Personality and social dysfunctions treated within it may be varied, though in this paper we emphasize the assistance given to patients whose principal symtomatology is drug abuse.

What do we understand by personality and social dysfunctions?

By this term we define those particular forms of psychic organization that promote a special manner of social integration, which induces the diseased person to sink in the "alienated pole" of the society he belongs to.

Thus the diseased person, trapped by a number of forces he does not know, suffers an identity disturbance but, also, he is socially condemned to not-identity as a person. He is sunk in contempt and indifference, and thus he begins his progress towards an irrecoverable condition, due to the chronicity his self is tied down to.

Some of these forces unknown to him are the actions supported by a social system that promotes certain cultural models for personal relationships.

The forms of submission of man to man, of man to the economy and the state, of countries among themselves, and the exploitation of nature by man, promote alienated and destructive relationships. These relations are supported by certain models of progress and development which, for instance, are based on particular production-consumption patterns and on the progressive concentration of political and economic power.

From this environment the addict emerges and, under a permanent compulsion towards self-destruction, he may end by being the repository of a set of contradictions which exceed him and which he expresses, before the external observer, as an objectification of the accusation implied in his existence.

We are conscious that we belong to an ailing society and we intend to promote other values supporting the promotion of the human being.

We know that, when assisting an addict, we are only treating the consequences of a problem which exceeds him largely and which encompasses us too. That is the reason why we have answers for the individual pathology, but many questions posed by the social problem denoted by the pathology still remain unsolved.

Therefore, our task should have a double purpose: to treat the diseased person and to work towards social health, that is, in the prevention and for the suppression of the conditioning causes of this epidemic of drug addiction.

We should not feel the addict as a stranger; we are accomplices of his same condition, in the sense that we are involved, essentially, in the same constitutive factors, even though we have been endowed with a different personality organization and an identity of a different quality, which gives us other capabilities of relationship and exchange with the surrounding world.

In agreement with this general presentation of the problem, we can consider the features that distinguish the ethical model promoted by the TC in the treatment of drug abusing people.

I will develop three themes:

1) The general principles that should rule the community organization.

2) The notion of therapeutic role.

3) The model of approach to the addict.

1) General principles that should rule the organization: the institution organized as a TC offers a restructuring social framework for the addict's personality. There are three basic principles for this transforming process to develop, namely:

a) The authority principle: one of the more consistent phenomena which account for the addict's anomy, are the serious failures in the paternal function within the familial structure from which he has emerged. This generates in him a deficient identification, absence of limits, confusion and fear regarding the surrounding reality, disorders in the handling of aggression and perversion of the vital values guiding his own actions. The addict requests, in multiple ways which must be understood, the reinstatement of this paternal function, so that it will allow him to halt his advance towards self-destruction and make possible a new organization of his internal world.

The TC, aware of this problem, grounds its structure in an authority principle based on love, respect and the guidance of its members towards independence of judgment; towards the achievement of a free self-determination, understanding freedom as active responsibility. The realization of this principle generates the establishment of a series of rules which organize the activity of the whole. These rules must be explicit and must involve a permanent analysis of people's actions with respect to them.

b) The principle of institutional environment: the authority model and the establishment of rules to govern the organization generate a model of environment for institutional work. This environment must always be an object of study and improvement, so that it may generate increasingly sympathetic bonds among the members of the TC .

"In this sense, the important thing is to understand that the rule must be observed and preserved, no matter which rule it is; that its infringement implies a consequence, and that this theoretical relation between the rule, its transgression and the immediate consequence operates, in practice, with equal smoothness" (2).

This will tend to promote, in members, a self-criticism that will compare the manner of satisfaction of the individual need and the needs and welfare of the whole. This promotion of a sympathetic attitude faces the addict with his fantasies of "individual liberation", with which he permanently tries to disguise his tragedy.

The series of rules which express the model of working environment has double purpose: that of guiding the institutional therapeutic function, and of being useful for the content analysis of the permanent "acting-outs" generated by the addict.

Any unexplicit aspect of the environment will generate confusion and will create a space apt for the development of serious institutional conflicts, the solution to which will imply a high cost in terms of time and effort on the part of community members.

"The environment is a goal to be achieved, which must be introduced so that the therapeutic process may develop. The environment represents the discriminating limit between reality and imagination" (3). And if we think, as Freud, that "... the new external fantastic world of psychoses wants to take the place of external reality" (4), we must understand that it is the environment model that makes possible our way of observation, analysis and modification of the patient's internal reality.

c) The principle of belonging to the organization: this principle is observed in the sense that one must be permanently aware of being a part of a structure.

From the point of view of the TC concept, the Institution is the basis for the members' activity, and each therapeutic activity acquires its meaning in relation to the whole.

Individualistic attitudes, such as solitary actions by sectarian subgroups, for instance, damage the sense of organic action of the Community, and must be analyzed as deviations that impair the therapeutic function that it must perform.

It is an actual fact that mental health establishments that do not carry out a systematic evaluation of their own performance tend to reproduce, within themselves, those pathological mechanisms that they purport to cure in their patients.

This is an institutional identification with the object of their work, of which we can briefly mention the following examples: the split in and isolation of different working teams, the dissociation of therapeutic and non-therapeutic activities, the absence of a responsible authority or the authoritarianism that promotes pathological rivalries ending in the generation of "acting-outs" by members of the staff, schizoidism in the transmission of information, the denial of conflicts existing in the institution, all of which produce a distorted view of the organizational reality.

The notion of therapeutic role: the community model enriches the traditional model of individual analysis. The patient is the active subject of his own treatment, within an organization designed to understand him, to help him change and in which he is respected as a person. Thus, in his daily behavior, he will show his capabilities and difficulties, increasing his possibility of insight, due to the multiple approaches to his behavior patterns that will be accomplished in the course of the different activities of the therapeutic program. He will be observed in his interaction when working in different groups, or when playing, eating or sleeping; his leadership style, his relationship with the organization and its rules, his behavior in critical situations and under which circumstances these arise, how he solves his gratification needs, etc., will also be noticed.

While he acquires a new dimension of himself and his disease, the patient will go through a learning process of reconnection with the world, in which he will be an active participant, and not a passive recipient of a treatment provided from the outside.

In this sense, the concept of therapeutic role acquires a greater dimension, as this function is not limited to the professional staff. It includes the capacity of any person to establish a vital bond that may be useful to understand a conflictive situation, to be a "mirror" for another's pathological behavior, to offer help and to preserve and improve the operation of the institution. On this same line, we believe that psychotherapeutic activities are nobody's private property, though different degrees of responsibility and expectations may exist, according to the position held within the formal organization.

All members of the administrative, professional and services staff must be trained, therefore, in a double sense: in their specific tasks and in the importance of their role in the institutions's operation, in the reasons and objectives of the different organizational modes of the TC.

No labor function may remain isolated from the community life, for an institution is nearer to becoming a TC when it develops in its members a state of permanent awareness of the goals it wishes to achieve.

For this reason the therapeutic role may be played by the patients themselves, and this is encouraged. Thus they are globally incorporated into the general activity, and they find it possible to adopt an attitude, inherent in the human condition, which allows them to perform coordinated actions of remedial effects for themselves and others.

The model of approach to the addict: Even though in previous sections the features of this mode of approach are suggested, I wish to make somewhat more explicit the vital point where the TC places itself to try to rescue the patient from the loneliness in which he denies and is a product of the isolation in which he finds himself. "... the addict confines himself to his toxic loneliness and confers his deprivation the dignity of a miracle plenty of meaning." (5)

The TC intends to move him by presenting the meeting with the other as one of the foundations of its therapy. This meeting is at the same time a discovery, insofar as the addict, from the narcissistic structure of his personality, denies the presence of the "other".

In this process, the addict finds that the "other" (person, group, institution) has a series of ideas regarding his or her self, body, sexuality, life and death. He discovers that the addiction develops due to the conflicts originated by those same problems, the addiction in which he dissolves his existence, in a magic, omnipotent attempt to face such problems by means of the idealized and destructive bond with the pseudo-object drug. Thus, he will find later that this pseudo-object is a carrier of death, which he had denied in his omnipotence and returns, sinisterly, under the guise of "pleasure", life or "paradise".

In this sense, the TC promotes the effort of constituting, in the first place, this duality, novel and regenerating for the addict. And while this "I-other" pair, determinant of a new structure, is developed, one enters progressively into the personifying stage of "we". We, working together in order to improve the quality of our life and building, a socially meaningful reference point becoming a new focus for organizing one's life.

Thus, we note that the addicted patient finds, in the TC, a different world of relationships that impress him and surprise him, because they place him in a different condition. They drive him out of his dependent and self destructive world, and engage him in a structure that, gives him some psyche on his own existence.

In this new alternative the possibility lies of encounter with life, with lov[redacted]nd the model of identity which will provide the capacity of active and creative integration into reality.

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A REHABILITATION PROGRAM IN BRAZIL

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When morning prayer comes to an end, sixty Brazilian youths in a group exchange handshakes, a pat on the shoulder, sing a hymn, and then wander off to their work assignments. Ask me: start of a day in a seminary? In a young peoples' retreat? No. It's the beginning of the day in a live-in drug-alcohol rehabilitation center on a ranch in Campinas, Brazil, and prayer is the first exercise of the day.

I founded this center six years ago; but as Padre Haroldo, the only name I'm known by in Brazil, and I am a twenty-one year veteran missionary there. I hail from the New Orleans Jesuit province and I was among some of the first missionaries to leave the United States when Pope John XXIII called for reinforcement from North America for the Church in Latin America.

The center is located on a fifty acre farm about twelve miles outside the city. There, with the assistance of a dedicated and qualified staff, I guide my young people through a nine month recovery and re-motivation program. In Brazilian, the official name of the center is *Fazenda do Senhor Jesus*. The English equivalent is *Ranch of the Lord Jesus*.

I really began my first work with problem youth - delinquents, alcoholics and prostitutes - way back in my seminary days. Then, in the 50's, to counter the rampaging gangs of the El Paso ghetto areas, I founded Our Lady's Youth Center. Today, it still provides sports and other recreational activities for young people. Some fifteen years after that El Paso foundation, in the distant southern hemisphere, I started the Kennedy Social Center, a trade school - so to speak - on the south side of Campinas, Brazil. That too, remains in existence today. Shortly after that, together with a Brazilian group of Good Shepherd Nuns, I opened a residence for babies born of mothers of the red-light zone. But when I saw the terrible toll in broken marriages and anguished homes caused by drinking and drugs, I decided to apply the best remedy I knew: provide a family environment for the addicted.

I began with a dream, a donor and grit.

I had the dream and I sold it to Mr. Claudio Novaes who bought property and building material for the project.

The property was set in an ideal location: a rolling countryside overlooking a narrow river provided the peace and serenity needed for healing. And its isolation at the end of a long dirt road kept the problems and distractions of city-life far enough away from us. A couple of bungalows on the land housed workmen and a handful of volunteers. Within a short time the largest of the structures was modified to lodge 12. We built a small but functional kitchen and dining area and a type of hall or large room which served as prayer-area, recreation hall, group meeting hall and a multitude of other purposes. Along the front of this same house, we built a wide veranda which over-looked all of our property and the river for as far as the eye could see. This first house has been re-modeled and re-modeled to keep up with our needs and even now it is undergoing enlargement and refurbishment.

So we had the dreaur farm produce. Our herd of cattle was increased through a donation from the Brazilian Jesuit province, and a Jesuit high school in Tampa, Florida, raised money for us to but a tractor.

Within a year we were over-crowded due to the number of applicants. By 1981 our ranch accommodation grew to three times its original size and we had 50 residents. With this growth other changes naturally occurred: we built a soccer field, a laundry, a carpentry shop and a garage for farm equipment. ur farm produce. Our herd of cattle was increased through a donation from the Brazilian Jesuit province, and a Jesuit high school in Tampa, Florida, raised money for us to but a tractor.

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I think that the success of this ranch rehabilitation center is naturally due to its demanding need and to its unique structure. When I began, I really never gave much thought to my methodology. All I wanted was something simple and workable. And did it ever work! We can't keep up with the applications. The waiting list is endless. And they do wait; simply because they want to come.

Jorge, 43, came to us totally dependent on alcohol. He had already hit "the bottom of the barrel." He had been a man completely lacking in self-confidence and couldn't relate to other people until he discovered the bottle. He told me, After downing a few shots, I felt different. The barriers fell and I was at ease in conversation. But unfortunately, I didn't stop there and people began to treat me like I was garbage. In your program, people treat me like a human being. You and your staff made me believe in myself."

The stories go on and on......Tadue, 21, came from a broken family and was so totally hung up on drugs that, as he explains, "It was an escape from what I thought was the drudgery of survival, of complete emptiness. I wanted to kill the torment, so I just drugged myself. I lived like a man already dead, a human vegetable. After nine months in this program, I feel like a new person with a free life, a real human being. I'm really happy. I feel ready to study, to work, and to live like normal people do. And God's become very important to me. From time to time depression still hits me. I know that I just couldn't stand it without him. He makes me strong when I'm weak."

The structure of my program - or really what it has gradually evolved into - involves a thorough approach to the addiction problem and tinges every area of life of the total person: intellectual, volitional, affective, and social, because the human person doesn't live for himself. He must live for and with others. So besides re-educating the person him/herself, we assist them in the crucial problem of returning to society and accepting this or her obligations in very dimension of life.

The daily prayer is an indication that the spiritual dimension is central. Though the program does nor force adherence to any particular church, it does demand that the rehabilitants confront their religious needs. Each one must take part in the spiritual activities like morning prayer and other moments of spiritual çconfrontation during the day. I believe that in every person there is something that calls out for God and wants to relate to him. So, I lead my rehabilitants in prayers that express belief in God, in his mercy. I try to reinforce in them the idea that we need to put ourselves at his disposal, concentrating on the power of his grace. We use the Bible and popular Brazilian Christian hymns. Hope for healing - any healing - comes from working on this spiritual dimension.

Secondly, I believe that the human spirit is an embodied one. Hence, our program stresses physical exercises of every type: body-mind coordination and relaxation, physical and occupational therapy, sports, and the constructive use of leisure time. I like to lead the residents in certain forms of Oriental prayer that integrate bodily activity with the inner life of the spirit.

As I see it, the two main forces for the type of healing we are seeking our spiritual and physical. These forces live within every human being. All that we must do is take the time and the effort to bring them to the surface and then utilize them to the fullest extent.

For this reason, my staff - an interdisciplinary one - is of vital importance to me. They are the ones who collaborate with me, according to their various capacities, to integrate the entire program and set into motion in each rehabilitant the forces below the surface. I work in the program in a general way as director and coordinator. The task of the staff is to meet the needs of each rehabililitant on a one-to-one basis and resolve individual problems and begin the re-structuring process and see that it is carried through to the end.

We have professionals and para-professionals all working toward the same goals. They include psychologists, social workers, ç educators, occupational therapists and ex-rehabilitants who have opted to remain with us because they have gone through the program, have first-hand experience, and as I see it, are in this sense among the most valuable staff members. Their perspective of rehabilitation is perhaps different than ours and they have the capacity to relate to our clients in a manner that no other staff member can.

With regard to our program structure, we conduct screening interviews, oversee testing, and run counseling and group sessions. We also offer courses leading to marketable skills that will later be useful in job placement services.

I also place great importance on the interaction of rehabilitants themselves. The new person who is emerging into a new way of life is living in a community of other persons who accept him as one who like themselves, is struggling and changing to become a new person. This mutual assistance is crucial to the program, and call it by any name your like, I see it as a sort of family structure that lends support and understanding at every turn in the road to sobriety. This is serenity in action: the ability to help and to let oneself be helped with humility and acceptance.

We do more than just pick troubled people off the streets.

We operate an intake center and detoxification program that lasts one month. Most of our clients come from the poorer classes and cannot afford to pay for services. So we've turned into a self- supporting operation. We sell our farm and dairy products and woodwork and other objects than come out of our carpentry shop and arts and crafts classes. But this is not sufficient. We seek donations from public and private sectors and from foundations both in Brazil and abroad.

We offer courses in various cities of Brazil for the average working person. These courses are based on the same type of spirituality we offer to our rehabilitants and we have met with great success. The donations from these courses are directed toward maintaining our rehabilitants through their nine-month program.

Our rate of cure for those who remain for the full-term is fifty percent, looking at it from an overall basis. It may be higher; but I prefer calculating it as realistically as possible.

I'm always open to new trends and ideas and new ways of meeting both old and new problems. Let me give you an example of how we must continually adapt our methodology and system. When I first began my work in this area, my program attracted men averaging thirty years of age and mostly addicted to alcohol and marijuana. Recently, there has been a drastic shift in both age and addiction, and we've had to shift our gears to meet the change. Our Intake Center reports an upsurge in high school drop-outs all under twenty-one years of age, and for the most part addicted to cocaine and amphetamines. This creates the need for new patterns of rehabilitation because the risk of long-term psychological dependency with these users is much higher than the persons we've dealt with in the past.

We've also entered the prevention arena. Communications is the name of the game in prevention: make both young people and their families aware of the problems, the risks, the effects, the means, the services. We began on one TV channel, once a week, in one city. Now channels in other cities are requesting programs and more than once a week. This new area of our work is exhausting and time-consuming but the audience is large and the feedback positive. We are hitting at least some of the people in some of the cities in Brazil. People I'm trying really hard to get to back me up are those who influence the young: artists, especially singers, entertainers, teachers, coaches, etc. We've got to hit these people and it them hard. They influence public opinion and are the idols of our young people. They set the trend and the others follow.

Another important area of both preventive and curative measures is the family. We plan to open family counseling service centers that will serve the families of young users. We will not close our doors to families with older dependents, but we see the real need for hard core work and services for parents of chemically dependent children who have not yet even reached high school age.

Just as I began my program with a dream, each person carries a dream and vision of life deep within him/herself. Unfortunately, that dream, for the chemically-dependent person has turned into a nightmare. My prayer, my work, my undying dream, is to help these persons once more turn their dream of a beautiful and fulfilling life into a reality. If I can do this for at least half of the people that I serve, then I know that my own dream has been realized.

REFLECTIONS ON GRADIVA TC IN ARGENTINA

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If we think as Martin Heidegger, that every word is related to an original experience, to a significant space, we should wonder about the meaning of the word Gradiva, which in itself leads to a therapeutic plan.

In this case the word comes into being not only as a fossil past, but as a potential drive towards the future. Gradiva acknowledges Freud's works as its foundation. But, which Freud? That one who teaches us that it is within language that the problematic horizon of the symptom must be deciphered A language that is the language of the family, the story of the family, and the story of the individual. A language that shows a social crisis through a symptom. The Freud that recalls in nostalgia the poets as the ones to understand the multiple sense of words and reality. The Freud who speaks of the linguistic meaning of the symptom; that appeals to feeling, to love, what Freud calls "the cure through love."

In 1972, we proposed to listen to the patients. We broke with the social conventions about madness. This was not a passive listening to the patients but active search that had to start from looking within oneself.

At this point, we realized that the institutional structure is important in producing change. The community should be a place to encourage questioning, to generate communication. To achieve this, we followed Maxwell Jones' theory of the therapeutic community, adapting it to our way of life. The democratic participation, emphasized by Mr. Jones, implies the possibility of setting language into action, which can eventually bring about growth in the patient because it allows him to symbolize. Language ought not be used for social control or in subjugating th patient. The different groups in the TC lead to resocialization. A language will develop that will recapture the story of the individual and the family. Through this conception, the TC as defined as a symbolic organism, not only a corrective process to bring about behavior change.

We take Pinel, Freud and Maxwell Jones' theory as the foundation for investigation in psychiatry, psychoanalysis and social psychiatry. Psychiatry frees the patient from chains, psychoanalysis releases the patient from guilt, and social psychiatry based on Jones' concepts of the TC, demonstrates the relationship between society and madness. These three discoveries described as psychiatric revolutions, have been extremely influential in psychiatric practice, but have not had much influence in psychiatric institutions. Gradiva has tried to provide an alternative to this paradox.

Family therapy, the fourth psychiatric revolution, will be frustrated if we do not change the majority of institutions which primarily articulate techniques of social control and subjugation.

For these reasons, a linguistic approach is important to set all the actors to confront the word. This acquires important characteristics if we understand what the word addiction means.

Addiction comes from the word adictum which means slavery. The addict does not speak. As he is not able to speak, he becomes a slave. He is marginal in the symbolic sense. Not being able to speak, the addict remains locked up in the quietude of non-action. The TC offers the support for the addict to speak, for the family to speak, for society to speak. The symptom of drug addiction is a caricature of what is called a healthy way of life. The technocratic society is generating addicts very fast in the same way that traditional society generated hysterias and obsessional neuroses in the big ballrooms of Vienna during the time of Freud.

What is remarkable in the family, is the "decay" of the father's image, a father who is absent or, if present, is overly narcissistic. He appears in the family histories of our patients as dead, missing, humiliated, denigrated, consumed in our consumer culture; the border-line father who is resentful, violent and a thief, distanced from what is shown to him as desirable to attain, but which he can only sparingly get.

We live in a suicidal civilization from which the addict is the perfect exponent. There are over 50 million addicts in the world, some addicted to alcohol, others to drugs and psychoactive chemicals. The slow suicide of the addict is the most evident example of what Freud in his work, The Ego and the Superego showed as a culture of destructive instincts. The ego ideal is no longer the producer of sublimations that are expressed in art and religion. It is the superego which submerges the human being in the tyranny of death.

We live in a society which has buried the great ethical systems and promotes the blind ethics of the marketplace. Through this our young people are converted into the merchandise of big business.

I believe that addiction, being a psychosocial pathology, needs institutional support to promote the symbolization of conflicts. The TC's main task is to interpret the addict's language and move toward rehabilitation. Healthy family systems need to be developed, and TC's must work with the family. The TC must promote health through play, where the creative act is associated with vital spontaneity. I think that human problems are the result of some deficit in the development of the child, in the lack of creativity when the child has no motivation to play.

Reaffirming the need of a space to play in a communitarian group implies a criticism of the automated, too serious and monotonous way of life that forgets about the feeling of happiness in being alive.

The TC needs to encourage health by encouraging its members to work inside and outside of the program, because man can discover the possibility of transformation while he performs meaningful work. The TC must promote health as a subject of discussion in every situation, including the school, the church, the university and the neighborhood. This service is needed in the community and the community will change for the better through this service.

THE THERAPEUTIC COMMUNITIES OF THE SOPIMUSVUORI SOCIETY

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The foundation of Sopimusvuori has been described elsewhere (Ojanen, 1984). Here I describe the development of Sopimsuvuori through those crises and challenges which have been met during its working history.

CHALLENGE 1: Swelling Mental Hospitals

The mental health district of Pohjois-Hame (in and around the city of Tampere) had during the 1960's a population of 300,000 and the number of mental hospital beds was over 1300 (about 4.5 per 1000). Mental health clinics existed, but a major alternative for practically all kinds of trouble, be it senility, alcoholism, or any kind of odd behavior, was the mental hospital.

The district director saw all this all right, but could not do very much because of custodial attitudes and old mental health laws. He initiated a home-care project, however, and wanted to show that patients could be taken care of in their homes, if properly supported. This study was a success in many ways, but it was not put into practice extensively.

OUTCOME: The home-care research group saw that there was a lot of rehabilitative potential in hospital patients, but very much could not be done in the existing mental health organization. Seeing this, one of the home -care project workers, Leena Salmijarvi (RN in psychiatry) , wanted to do something and arranged an apartment for six women patients who all had been at least 10 years in mental hospitals. The district director supported her in this experiment.

CHALLENGE 2: Helplessness of Patients

The condition of the patients was very poor. They were released with great doubts and told, "You cam always come back to the hospital where your proper place is."

OUTCOME: Though the patients did not much oppose the move into an apartment, they were quite helpless at firs. They were poorly equipped for every-day living, and they could not use the bus, telephone, shops, etc. Leena Salmijarvi (hereafter known as L.S.) had to help them daily. She stubbornly showed them how to make food, and how to manage practical matters. After a difficult start the women began to blossom. They really enjoyed their new life and took things energetically into their own hands.

CHALLENGE 3: Losing the Apartment

The owner of the apartment died and the women lost their apartment. At first it was a great shock, and when the hospital could not give them any living quarters outside the hospital, this brave experiment seemed to have come to an end. The women had to back to the hospital.

OUTCOME: The women did not agree with this verdict. They acquired homes for themselves independently, because they did not want to go back to the hospital. Since then, no one (except one for a very short period) has come back to the mental hospital.

CHALLENGE 4: Looking for New Chances

Courage among those people who had participated in the experiments increased. But what could be done? L.S. saw a newspaper advertisement, where the upstairs premises of an old people's home was available for renting (because of new safety regulations it could not be used any longer for the care of old people).

OUTCOME: Six new patients moved into this place. Officially they were in home care under the responsibility of the director, because this had been the only way to release them from the hospital. The treatment of patients was in many ways similar to the care of old people, who still occupied the downstairs rooms.

CHALLENGE 5: Continuity of Work

The old people's home was ultimately closed and the whole place was offered for renting. The patients had been there for two years and they still needed care. Now it was crystal clear that there were many similar patients in hospitals waiting to get out. Many were in a fairly good condition, but had no place to go. Mental hospitals could not support this kind of activity.

OUTCOME: L.S. wanted to continue the work and got support from any persons. When no other ways seemed available, it was decided to found a Society for placing patients outside mental hospitals. L.S. personally with her friend promised to pay the rent for the first three months. The society was founded in 1970.

CHALLENGE 7: Shortage of Money

In the early years even sustaining the first hostels seemed impossible. However, L.S. and others had definite ideas about developing Sopimusvuori. New hostels, a workshop, a day-center were on the list.

OUTCOME: The founding members had to resort to their wallets and personally guarantee bank loans. Voluntary work was started and with it "the spirit of Sopimusvuori" came about and has stayed since. New places, in addition to the above, were founded without knowing who would be paying for them. Of course, everything was done as inexpensively as possible. All premises were old and often in poor condition. The first job was to do some renovation work at these premises. Here patients and volunteers were often of great help.

CHALLENGE 8: Philosophy and Working Methods

It was not obvious how the various places should function, though L.S. had visited Great Britain and was familiar with the ideas of the therapeutic community as designed by Maxwell Jones. She is very practical minded and does not put her fingers in her mouth when a crisis is at hand. She had a direct way of doing things and this was also a model for others. But was it enough? There was not much training or discussions about ideology or work-methods. There was too much to do all the time. New workers were supposed to know what to do and mostly they did. However, ideas of therapeutic community did affect the workers of Sopimusvuori. What is it and how should it be applied? On the other hand, there were pressures to make it good for patients, to compensate for their sufferings. The hotels should be some kind of convalescent homes, where the clients can just enjoy their life. In many places the clients accepted the services where they got it and protested if they were required to do something for themselves. In the free and warm atmosphere of the hostels and day- centers they were often very passive and took no responsibility.

OUTCOME: Just plain common sense told us that the full-service idea could not continue. some of the communities had already started to cajole clients to participate and to work and others followed them. Participation was now required as a matter of fact. This change did not result from any theory, but from experience. Many of the workers were laymen and did not know much about schools of psychotherapy. However, at the same time, the principles of therapeutic community were more openly discussed. Most, perhaps all, of the workers believed in these principles. They wanted the communities to be democratic, equal, open and warm. Some felt that a good atmosphere brings out the best in the clients. This did not work out too well, as was told above.

There has been a continuous dilemma in some communities. Where do you draw the line between democracy and authority? Some of the workers believe very strongly in democracy, responsibility and tolerance. It seems that both their profits and their losses have been greatest. Somewhat later the staff was familiarized with the concepts of social learning and most of them have taken courses in transactional analysis. The training of social skills approach has been easy to adopt because it fits well with the practical attitude. It is a general feeling among the workers that theories are not very helpful in everyday work.

CHALLENGE 9: Hostels Make Clients Passive

In about four or five years it was clear that the hostels, though they were small (10-20 beds), did not work properly. clients stayed the whole day alone in their rooms and ate what and when they pleased. Many did not car about their appearance or the environment. There was no group-feeling among the clients. Though the hostels were supposed to be only temporary living places, there was not very much movement to private or community housing.

OUTCOME: In a few years hostels were abolished. Instead small homes were founded. Clients moved into these Rehabilitation Homes (RH's) from the hostels, and as a first step in Sopimusvuori. The RH's are for 8-16 people and each RH has a staff of 1-3. In most RH's the daytime is highly structured consisting of home-care, making food, various groups, etc. Similar ideas are applied in small homes in which there are no daily workers.

CHALLENGE 10: Response of the Community

The reactions of nearby people have been quite variable. Especially the second RH had conflicts with the people who were living in the same building. The passive clients made no noise or harm, but their presence was too much for some. This RH moved into another place. Also, it was difficult to get enough apartments for clients in order to get them out of the Sopimusvuori.

OUTCOME: The above example was actually the only one. Sopimusvuori has tried to be very open in many ways. Anybody can visit the communities. Gradually Sopimsuvuori has acquired many friends and volunteers. There is now no shortage of apartments. Each week more apartments are being made available to Sopimusvuori.

CHALLENGE 11: Visitors

Sopimusvuori had some visitors in the first working years, but from 1975 onwards there has been an increasing trend in the amount of visitors. First the staff and especially the clients protested about it. Visitors clearly invaded their privacy. Many clients simply vanished when visitors came.

OUTCOME: Visitors could not be turned away, especially not when they came from mental hospitals and foreign countries. Soon clients started to adapt to the flux of visitors and noticed that they were living in a special place. They were also given a more active role in showing the places and telling about them. They could also earn extra money by making food for visitors.

CHALLENGE 12: Staff Independence and Responsibility

During the first years the staff complained often that they were given too much responsibility. in hospitals you can consult in difficult matters or can give the responsibility to others. The staff also wanted clear advice as to how to treat the clients. What are the objectives of the various places? When should a disturbing client be taken back to the hospital?

OUTCOME: The critique was often justified. Nobody knew what was coming. The staff simply had to take the responsibility for their communities. They had practically free hands. Training was increased and each community was given a counselor with whom they met weekly or twice a month. The problems solved themselves when the experience increased and autonomy became a way of life.

CHALLENGE 13: Integration with Hospitals

We are now coming full cycle. The first challenge was the swelling hospitals. Though the number of beds has decreased to 32.9 per 1000, the effect of Sopimusvuori has not been as great as it could be. It is still a private association, obviously very useful to the district, but it is not fully integrated with other mental health services. There has been, now and then, empty beds in Sopimusvuori, because "there are no suitable patients to send." The rehabilitative steps have not been clear enough. The closing of mental hospital beds is opposed by city officials, because they want to use them for the care of old people.

OUTCOME: We are looking forward quite optimistically. The present director works for an integrated, stepwise system and believes that part of the hospital beds could be closed. A large research project has been developed in order to find new solutions and ways of treatment and rehabilitation.

RESEARCH RESULTS

Follow-up studies were started in 1971 and after this many studies have been made (Ojanen, 1984). Here I list some generalizations based on the research.

1. A typical client has a diagnosis of schizophrenia, is single and has been at least for one year in the hospital. The first clients had been for 10-20 years in the hospital, but now more acute young people are coming in. Women are in a small majority among the clients.

2. The best results have been achieved among middle aged women (40-70 years old). Also, men of similar age do well. Poorest results are among young acute schizophrenic clients, regardless of whether they are men or women.

3. During the first month many clients have difficulties in adapting to Sopimusvuori. About 20% of the newcomers just look around and go back to the hospital or to their parent's home (it is easier to leave, if you have a place to go). Those who do not stay are on the average in poorer condition and have more negative attitudes.

4. When a client has been in Sopimusvuori for over two years his chances of going back into the hospital are 1 in 10.

5. A minimum four year study gives the following results for the rehabilitation homes, which are the first step after the hospital

Rehabilitation Home	16%
Hospital	18%
Small Home	14%
Own Home (or parent's)	44%
Dead	3%
Other (no data)	5%

6. A matched comparison group selected from hospitals before Sopimusvuori was functioning shows that Sopimusvuori works especially well with patients who came from small local mental hospitals. Before 1972 there was practically no outlet for these patients. They stayed in the hospital until their death. They often got good care, but there were simply no places to put them.

7. In the early studies the behavioral ratings by the staff revealed little changes on the average during a two year follow-up, though those who went to the hospital got worse. Either the changes really are small and take time or the method does not reach them.

8. (Partial answer to the above). During three year follow-up the stability of the clients' condition is amazing. Re-test correlations in social skills, anxiety, assertiveness, activity are between .52 - .80 (staff ratings are lowers).

9. Positive changes are generally small and mainly in social skills. Clients' own evaluations change even less. The self-concept of clients seem to be very stable.

10. Staff and client ratings do not correlate much. Many clients either overestimate or underestimate their skills. The above results concern mainly the follow-up of clients. In my studies the atmosphere and functioning of the communities has also been measured using either participatory observation or rating scales. The next results are from these.

11. In 1976, Rudolf H. Moos' COPES was used in the day treatment center and the workshop. The staff saw these communities having more support, practicality, personal problem orientation, and aggression as well as less organization and control. Participatory observation confirmed also that the staff underestimated its control. During the early years staff control was thought to be against the principles of therapeutic community.

12. New rating scales adapted to our communities were made in 1979. Compared to hospital wards the rehabilitaiton homes were more democratic and organized as rated by the staff and clients. Now the staff rated their control realistically.

13. The rehabilitation homes are quite different in their atmosphere. Some are practical or control-oriented and some stress the ideas of the TC. The atmospheres are usually quite stable, though there are exceptions: one rehab. home has evolved from control and clarity to spontaneity and autonomy and back again to greater control.

14. The latest large studies show that Sopimusvuori has, according to the ratings of the staff, successfully avoided bureaucracy. Especially, hospital workers tend to complain about their working situation: no flexibility, too little information as not understand or support, etc. These complaints are rare in Sopimusvuori and also in other small organizations.

SUMMARY

Even in the beginning of the 1970's people working or associated with Sopimusvuori were quite pessimistic about changes in the care of long-term patients. Thousands of visitors came and went, some enthusiastic, some just watching this curiosity. Now we can see that we were too pessimistic. Two private organizations have been created in Helsinki and its vicinity. The mental health law allows all kinds of sensible alternatives now, and actually encourages these alternatives. Rehabilitation homes are planned or are already started in most of the 21 mental health districts. All this has happened in less than five years.

Does this turn out to be a real change? It is too early to answer, but one optimistic sign is the large project called "The National Program of Research, Treatment and Rehabilitation of Schizophrenia" in which over half of the districts participate in actively. in this project, the goal is to decrease mental hospital beds and to find working alternatives for long-term patients. This project was started in 1983 (its planning started three years earlier). The following early positive signs can be listed:

- hospital beds have been closed
- new alternatives have been found
- a few impressive social skill programs have been created
- hospitals are renovating their wards and making them smaller
- planning of treatment programs in hospitals and in alternative care is emphasized.

Major problems remaining seem to be:

- lack of sheltered work
- overburdened mental health clinic and inadequate home-care
- deficiencies in training of mental health workers
- bureaucratic mental health system

What are the strong points of Sopimusvuori? Can the Spirit be analyzed? Here are some catchwords which describe the Spirit and Flesh of Sopimusvuori:

- Small is beautiful
- Don't lose your senses
- Who else is responsible but you
- Three does not make a crowd
- Don't dig into your past failures
- Let the heart rule more than the book
- Never give up hope
- Dirty hands do not lower your status
- Plan ahead, but give room for spontaneity
- Life is empty without parties.

Some of these descriptions are cryptic and need clarifying. People of Sopimusvuori feel now that there is not need to grow any more. Our Workshop is still growing but 300 beds or daily places is the limit. In most communities the number of clients is around 10-20. Only the sheltered workshop is markedly larger (60). The workshop has now some problems bake clients can withdraw quite easily and it is easier to skip or leave a larger group. Each client belongs to a small group, however, and this gives him support and security.

By senses we mean a practical mind. Usually there is a common sense solution to each problem. Often it helps, if you boldly take a hammer and nails, or pans and kettles, and start learning things with clients. There are no strict work roles for the staff. Hospital derived models must be discarded in Sopimusvuori. Common sense and dirty hands aim at normality to the greatest extent possible. Do as everyman does in his or her home.

Like many other communities we stress many-sided interactions. We don't have resources for dyadic therapy and became most clients have problems in groups, it is natural to stress the value of group- work. Clients are very vulnerable if they have not been able to form bonds and relationships.

We have an antipathy against patient papers and cards. We prefer not to have a patient's diagnosis and related hospital data available to us. In many places we do have a short questionnaire, which lets us know where the client is coming from, why he came, and what are his plans for the future. In the communities the clients are not encouraged to talk about their symptoms and past failures, because to do so would seem like an alibi or attention-getting.

In most communities there are strict rules against alcohol use, violence or smoking inside (fire hazard in old wooden buildings), but other rules come and go. In many communities life is quite spontaneous: food need not be ready at a certain hour. Small communities allow much flexibility. However, without planning, the communities would not have a clear view about the future. Norms and schedules give clients the structure they need. Schizophrenic patients do not usually stand much chaos and spontaneity.

Special occasions are very important for the communities. The society and communities use any plausible occasion to celebrate. Lately dinners in the finest hotel have been very popular, similarly travels abroad. Sopimusvuori has big parties during its yearly anniversary. Special days of each client are also celebrated.

Hope and responsibility are abstract words and difficult to achieve, but whenever a client can do something, he is allowed to do it, if possible. There have been many disappointments, but we consciously try to forget thoughts like "he has already tried unsuccessfully" or "she will not change no matter what you do." Hope can be aroused by small mastered steps, new friendships, and working for the common good. Slogans are used very little to bolster low self-esteem and hopelessness.

The work of Sopimusvuori is sometimes criticized because a clear theoretical base seems to be lacking. This critique hits the target. Sopimusvuy'ori does not have a theory which could be a rationale for every day decisions or from which the program is planned. We have rather the "Spirit", a special work-evolved ideology. some of its features were listed above. Many of the members of the staff and supporters uphold the Christian ethos, and a great majority would co- sign Victor Frankl's ideas. Principles of therapeutic community fit here well, also.

Personally, I feel that there are not very good candidates for a suitable theory. Social learning principles are well suited to the beginning stages of rehabilitation, where staff control is natural. Here i mean programs of the type which utilize the token economy. The principles do not work if they are watered down. Some of the learning principles and can used in problem solving and social skills training, but I am not sure how much more can be achieved except with common sense.

Psychoanalytic or loosely psychodynamic theories are even of less value. Long term patients' abilities to discuss or gain insight are severely handicapped. Finding out early traumas is a completely wasted task. Similar, "soft" theories based on psychoanalysis, like transactional analysis, is of dubious value, too, though it might be easier to point out negative ways of interaction and show how to correct them.

Well functioning communities or programs seem to rely on either Spirit or Control or sometimes on both. Talking about theories is often preposterous. Effects of good programs are simply faith, authority (or control) and practice. All these seem to be working at Sopimusvuori. Here faith has to be understood broadly. Faith includes trust, expectations, involvement and hope. Both parties have to believe that the treatment is useful.

We believe there is potential in each patient or client. We believe that when a client behaves normally, it is because she is expected to do so. W know that he have gained useful knowledge working in our communities and thus have authority based on it. We have faith in our methods and we hope this faith become communicated to our clients. This is our theory, or rather our Spirit.

I am not speaking against theory. It is easy to describe what we want from good theory. They should be general, precise and simple (Thorngate, 1976), and have truth, beauty and justice (Lave & March, 1975), or simply theories should give us ability to predict and control. Unfortunately, Thorngate has persuasively argued that a social psychological theory cannot be at the same time, general, precise and simple. We have to give in somewhere. Principles of TC are general and perhaps simple, too, but not precise. Learning theories are often precise, but lacking either generality or simplicity.

Two features of our clients and patients seem to direct our selection of theory: homogeneity and stability . If our clients are very similar and their condition is stable, a precise theory can be used, but if they are dissimilar and unstable, only a general theory is possible.

Our clients are a heterogeneous group. A few are finding normal work for themselves and they can give up their pensions. Some barely manage with their symptoms and are able to achieve by working a weekly salary of 6 marks (one dollar). Some should be in the hospitals but we do not give them up so easily. A solution would be a selection of homogeneous clients in each community. Until now this is strongly opposed, though we have one place, where young people are usually directed. Thus, in these conditions, our theory can only be general: we are trusting our Spirit.

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A.R.E.B.A.-CASRIEL INSTITUTE: A DIFFERENT TC

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The title of this presentation is "AREBA-Casriel Institute A Different TC." AREBA stands for Accelerated Rehabilitation of Emotions, Behavior and Attitudes. In 1969, Dan Casriel founded the Casriel Institute and, together with Ron Broncato, AREBA. Both are located on West 57th Street in mid-town Manhattan.

A different TC may sound tautological since every TC is different from all others. I don't mean to imply that AREBA is unique among TCs. Casriel's therapeutic system, the New Identity Process, had been adopted by TC's all around the world. Nor is AREBA the only TC that treats a mixes population of drug abusers, alcoholics, young delinquents, anorectics, non-organic manic depressives and neurotics. Other TCs have decided on urban locations, and many, like us, are private, independent from the external control associated with public funding. The need to offer different kinds of programs for different clients has become increasingly a matter of common knowledge.

First, I will discuss the kinds of clients we deal with and why, then I will speak about our structure and therapeutic techniques.

We have applied for and hopefully will shortly obtain full certification and thus third party reimbursement. Till now, only a minority of insurance companies have agreed to reimburse our fees. Our program is therefore relatively expensive ($1,100 per week for first phase or intensive experience, $660 per week for second phase and $330 per week for third phase) In total the average cost for the c full program is approximately $40,000. The high cost of the program combined with the relative unavailability of insurance reimbursement has offered us a few advantages; mainly, however, it has presented us with challenges to which we have learned to respond.

The primary advantage is that the self-selection of our clientele allows us to work with people who are literate, many of who possess good verbal skills, and who come from an environment which is, at least socially, not too destructive. In addition, nearly all of our clients enjoy a significant level of family support and involvement. The chief challenge is that our clients, paying for their AREBA stays out of their own or their parents' pockets, often come to us having tried other therapies or programs that were free or at least less expensive, shorter in duration and less demanding. In more than 60% of the cases, we are asked to succeed where others have previously failed. Often, we are not even the second or third try, sometimes the eighth or ninth.

As we all know, when motivation and commitment are very strong, chances of success are high with almost any kind of treatment. Thus, accepting those who have already failed in another kind of treatment means working with a low-motivated clientele.

Why we treat a mixed population is more than a choice. It is part of our deepest heritage. Doctor Daniel Casriel founded the AREBA-Casriel Institute in 1969 after helping to establish Daytop Village, a prototype for publicly funded therapeutic communities for drug rehabilitation. He enhanced the successful Daytop Village methodology with new, more innovative approaches. At the same time, he created an atmosphere that would not be alien to the lifestyles and values of our patients. Another of Casriel's goals was to intensify and thus shorten the length of the program. AREBA, as I said before, shares its facility, on different floors, with the Casriel Institute which offers individual and group therapy to outpatients.

In the beginning, AREBA residents did not attend what we now call emotional groups. Then Casriel decided to allow a few residents to participate in evening out-patient groups. The results of the experiment were so exciting that after a while, more and more residents were participating in out-patient groups. The last step was to create daily in-patient groups and to fully integrate emotional work into the program.

At that point, some out-patients with non-drug related problems were admitted for what we still call the AREBA intensive experience. This consists of an initial period of two to six weeks of residential treatment, including attending two to three groups a day and participating in all family activities when not in a group. Obviously, the difference between the symptoms of this group and those of our typical patients necessitated a different therapeutic approach. On the other hand, we (and when I say we, I'm speaking of staff and residents together) could identify many similarities in the emotions and attitudes of these two different groups.

Our staff was and continues to be trained to work with the non-drug abusers among our clients. Those counselors who are graduates of AREBA or another program, who lack the background necessary for this task receive specific in-service training an supervision by the credentialed professionals who comprise one third of AREBA staff.

Once a week, a full morning is dedicated by the staff to our ongoing meeting that can be structured either as a seminar or as a didactic group led by a therapist external to AREBA, who uses AREBA-like therapeutic techniques in this private practice.

Combining different kinds of clients obviously makes our work a bit more difficult, but offers certain advantages for the intensive patients and for the drug abusing population of AREBA. Through living with our long-term residents, sharing feelings, confronting eachother's attitudes and consequent behavior, our intensive patients learn that drugs are often just a different and more overt self-destructive answer to the same emotional disease. They learn that when not endogenous, their symptoms are interchangeable and that the way inadequacies are acted out can be a choice, which like other choices can be remade or corrected.

A person with symptoms which are not drug-related is often very self-indulgent. There is a wide cultural acceptance of the neurotic who claims he is not responsible for his behavior choices as if emotional disturbances would be the equivalent of a loss of free will. This person learns that his symptoms are just a different answer to similar problems faced by the drug abuser. If one places demands with love, concern, warmth, as well as the rigid consistency, it is possible for the patient to give up his symptoms, thus allowing him to re-evaluate his behavior.

For the drug abusing residents, on the other hand, the advantage lies mainly in the realization that staying clean may not be enough. They must learn why they turned to drugs, understanding that even people with no drug history can be unhappy until they deal with the underlying reasons for their disturbances.

As I just explained, AREBA has always had a mixed population and çits staff has always been trained to work with different kinds of patients. In the last few years, something else has evolved.

When Casriel and Broncato established AREBA, it was strictly for drug addicts and other infantile, non-functioning personalities. In other words, AREBA was for those whose lives were at stake and who were therefore ready to commit themselves to a long therapeutic process. In the past 15 years, unconventional therapies, such as the New Identity Process and the TC treatment modality have gained a wide acceptance, respect and attention. As a consequence of this cultural shift, more and more of our clients check into the full program not to save their lives, but to improve the quality of them. We have in-patients who were or who would be labeled in classical therapy as manic depressives, neurotics, anorectics, bulimics, etc., etc. These are people who could also benefit from non-residential treatment but who make the decision to devote a short period of time to work intensively in helping themselves.

The best example of this shift may be the family of six: divorced parents and four children, two of them heavily involved with drugs. One overdosed and died. The other came to AREBA, split, came back and split again, not responding to therapy. The other two children were not into drugs at all, both responded to the extremely painful family dynamics through withdrawal and depression; the girl also had food-related symptoms. Both were unsuccessful in other kinds of therapy. At different times, each decided to try AREBA. One graduated over a year ago and is now doing very well, the other will graduate shortly.

Research has proven that whites, and upper middle class drug abusers (the vast majority of our clientele), show more signs or ç psychopathology than other ethnic and class groups (you have to be sicker to break a stronger taboo). We also know that during treatment, many of them begin to show pathologies that were hidden by the self medication of their drug abuse. For the addict, the addiction is obviously the presenting symptom at the beginning of treatment. As treatment progresses, however, we recognize that the difference between the underlying problems of former addicts and so called "straights" is less significant than commonly believed.

In the last two years, we have also developed an intensive, short term treatment program specifically structured for the chemically dependent executive. Participants have professional, career and family responsibilities that necessitate a customized therapeutic and counseling approach. Patients begin with four to six weeks of intensive, in-patient involvement which includes detoxification, psychometrics, psychopharmacological evaluation, group and individual therapy, educational seminars and therapeutic community involvement.

Following this initial period, the clients return to their jobs on a full-time basis while continuing to reside at AREBA. Each evening, they engage in groups, meetings, seminars, and individual therapy focusing on actual life situations and work-related problems. Increased amounts of time are spent at home in order to resume their family roles. Family members are strongly encouraged to participate in weekly counseling sessions along with parents, spouses and sometimes even the children of our residents.

After four to six weeks, patients return home. They attend outpatient groups and receive individual therapy. Family counseling çcontinues for approximately four to six months.

We have also developed a cocaine aftercare program for those who have recently experienced in-patient treatment in short term usually hospital based program or for those whom inpatient treatment may be unnecessary.

Our long-term program, like those of a majority of TCs is divided into three phases. The three phases total about one year generally with first phase occupying a bit less than 50% of the total. Although I'm sure most of this audience is familiar with program structure, I'd like to briefly outline the AREBA structure. I'll try to explain this as best I can in the least amount of time.

In the first phase, the AREBA resident is immersed in a highly structured, supervised environment. The day consists of meetings, seminars, individual and group therapy sessions, and specific work responsibilities, the successful performance of which earns the resident privileges and higher levels of job responsibility within the program's structure. Throughout phase I, he is gradually exposed to the external world.

In the second phase, the resocialization process takes place on a full-time basis. A school aged resident returns to school. Others begin to work outside. The AREBA family member in second phase is involved in various group and individual therapies, mainly in the evening, as well as marathons and minithons on some weekends. He receives guidance in seeking out new friends and in fostering new kinds of relationships.

In the third phase, an individual continues in school or in his job. He lives outside the therapeutic community, often sharing an apartment with friends who have gone through the program. He still ç attends evening meetings, individual and group sessions. As he learns to adjust to the outside world, his involvement with AREBA gradually diminishes. After some months of living symptom-free and fun functioning socially and vocationally, at or near his potential, he graduates.

After graduation, we offer an optional post-graduate program. For a relatively small fee (equal to the cost of two weeks in first phase) the graduate has, for a period of 5 years, free access to all that we offer to our residents, including unlimited residential treatment, if needed.

This may sound like a guarantee of our product. In one sense, it is. We are a private company and we want people to know that we believe that what we produce is good. But even more than that, we want our graduates to feel free to ask for help when they need it without having to seek economic support from the family from whom we've taught them to be independent.

As I said earlier, our facility is located in mid-town Manhattan. This was not an easy choice to make. Since we are private, we are forced to pay for our building on the open market and I'm sure everyone here is familiar with the inflated real estate market in New York City.

For as much or even less, we could afford a beautiful estate in the country, complete with a pool, tennis court and other amenities. The air would be cleaner and our clients would probably be happier.

On the other hand, such an accommodation would shelter our residents from reality. It is our belief that they must begin to learn how to deal with reality at a relatively early stage of the çprogram.

We could have adopted the two facility solution to this problem of location which many other TCs have adopted. We could have had one facility in the country for the intensive initial stage of therapy and another in the city to be utilized by those residents in the later stages of resocialization.

We have chosen, however, to locate our program in the city and to operate all three phases in the same urban location.

The chief reason for this, aside from the unparalled availability of educational, vocational and cultural resources is our desire to keep our program short. Removing our clients completely from the outside world would require the luxury of a long period of readaptation. We also feel that such seclusion is unnecessary if there is close monitoring. We certainly know that our job would be a lot easier if we took more time. However, when it is possible to achieve the same result in a shorter time, we would rather choose that option.

As early as their second weekend in the program, our residents can earn the privilege to go out for an afternoon with other members of the AREBA family. After four to six weeks, by vote of their peers, they can be accorded the pocket money privilege. This privilege entitles them to $10.00 which we teach them to budget. We control the spending of this money by requiring them to obtain receipts for all money spent and to exhibit these receipts in a weekly meeting.

At this point, we send them out first with other residents and then by themselves for errands, medical appointments and to shop for personal needs with more and more money. Obviously every time they come home, they are seen by a staff member to whom they report ç thoughts, fears, temptations and any changes they experienced.

After the first few months of first phase, our residents earn a privilege which we call "socializing" which allows them to go out in the evening once or twice a week with at least one of their peers to clubs, discos and other public places. The goal is for them to meet positive people. After a screening session, people from the outside are allowed to date and establish relationships with our residents. By the time they get to second phase and are required to find jobs, they are generally self-confident enough to deal with their fears and to overcome them even though we are consistently encouraging them to acknowledge those same fears.

The reason we decided not to separate first from second phase different facilities is simple. Our second phasers are the best role models we could ever offer to our first phasers. Seeing people who have undergone the same therapy to solve the same problems immeasurably helps our new residents to develop trust and confidence. We encourage them to go out together on their weekend requests. Once a week, they participate in the same confrontation groups; the sensitivity, understanding and leadership shown by those in second phase to younger members of the AREBA family, is carefully assessed as a measure of their growth.

We also think that this kind of interaction provides very positive reinforcement of the values learned in first phase. Sharing certain dynamics even on a part-time basis with our newer residents is a good way for those in phase two and three to remain in touch with the basic principles they previously learned.

On the other hand, we demand that those in first phase assert themselves and the values that we are teaching them. Since it is obviously more difficult to confront someone more advanced in the program than a peer, learning to do so is very beneficial. Assertiveness is an important area for the kind of population we are dealing with, many of whom come from hyper-protective family environments. The manner in which days are structured and the tools (verbal reprimands, slipbox, pullups, different meetings, etc. etc.) we use are more or less similar to the majority of TCs. I don't think there is any need to explore them in depth here, but I want to stress that since the inception of AREBA we have chosen never to employ headshaving, signwearing and other such techniques that in our judgment are unnecessary.

More interesting are the therapeutic techniques we do use. Casriel wrote about the New Identity Process that : "Despite the theoretical structure of my groups, I feel it is the process itself which is more important. The process involves more than sensitivity groups, more than encounters. I occasionally try new exercises and techniques, experiment with different group formats, add to the theoretical basis of the process new insights and crystallizations of old ones. Our group method is constantly changing".

Right now we have in AREBA eight different group leaders who run about twenty groups a week, covering the three phases, intensive, executive and out-patient programs. None of us runs a group in precisely the same manner as another. In addition, the input of the trainees who often assist us frequently adds something new.

Given the time allotted to this presentation, it is impossible to adequately describe a theoretical model of these groups. Anyone who is interested in learning more about this subject should attend the experimental workshop in the N.I.P. that is scheduled for the day after tomorrow.

I will therefore limit myself to illustrate what these emotional groups have in common. The goal is to help the patients get beyond their symptoms quickly to the feelings and attitudes that are their genesis.

Participants in our groups who have gone through the same experience as our newer residents are the ones who encourage newcomers to express their feelings honestly. They can easily spot any phony attempt to hide or disguise real feelings; they can offer support and understanding to anyone who places himself in a vulnerable position.

On the other hand they can confront and demand that the newer members transcend their fears and resistance (as they were able to do) when those fears become immobilizing and prevent deep and total sharing.

Sometimes we start a group with a session of "telling secrets". This is an easy task for those who have done it before and have felt accepted after expressing thoughts, feelings or fantasies that in the past, would not have been shared. For one who has never done this before, it is much more difficult but is made easier through the encouragement and example of others.

Obviously, getting to know each other on such a deep level helps to establish, in a matter of weeks, a quality of friendship and trust that takes years of acquaintance to develop in any conventional setting. These friendships may well be the most important basis of a successful program, as they are indispensable to the reconstitution of a superego and are the greatest help in overcoming moments of crisis, doubt or discouragement.

Helping our patients get in touch with feelings related to the past, almost always unexpressed and repressed for a long time, is the first necessary step. We then must help them to overcome the attitudes which they developed about their feelings, anger is dangerous, nothing should scare me, only wimps cry, etc., etc. Full bodied emotional expression in the form of screaming in fact facilitates our basic therapeutic goal.

The way we help patients to become comfortable with their feelings is by accepting all of them non-judgmentally.

While involved in this kind of emotional work, our patients are encouraged to "bond", i.e. to experience physical closeness and emotion openess concurrently. We do this by holding hand, hugging and nurturing. Merely talking about feelings doesn't make other people feel you. Screaming your anger or your fear, crying when in pain, hugging to give love and feeling pleasure while receiving this kind of attention is what breaks social, verbal, religious barriers, and as Casriel once wrote: "When the facade is stripped away, the feelings we all show are astonishingly similar". Becoming reassured that you are still lovable when you are angry, scared or in pain is the most effective way of clarifying negative behavioral patterns based on historical expectations. In this way the patient can learn to adopt new behaviors, clearly identify their real needs and develop competences in meeting these needs.

The sum, total of all these points is a reflection of AREBA's long experience, our new ideas with which we have experimented, our mistakes that we learn from and corrected and the invaluable input of our professional staff and trainees who have come to us from throughout the world.

All of these sources enable us to offer a constantly evolving "product", not simply a copy of something else.

The philosophy that guides us can be summed up as follows: "when you offer the best that you can, there is no reason why everyone can't be helped to get better".

In an effort to make our program available to at least a few young people who do not come from privileged backgrounds, AREBA executive board created Daniel H. Casriel Memorial Scholarship which funds the treatment of worthy candidates who are in need. I would like also to announce a second scholarship fund to honor the memory of Robert Rathman, our resident director who died two weeks ago. He was an AREBA graduate who spent the last 4 years of his life giving back what he learned to many grateful men and women, including myself. It is also to his memory that I would like to dedicate this paper.

APPLICATIONS OF GESTALT THERAPY IN THE TC

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During the last ten years, Gestalt Therapy techniques have increasingly been incorporated into therapeutic communities, representing a relatively straightforward way of addressing some of the clinical dilemmas presented by a substance abuse population. This brief paper will describe some of those uses in preparation for a demonstration workshop at the conference.

Gestalt Therapy first became visible in the 1940's, when its founder, Frederick (Fritz) Perls began to depart from his training as an orthodox psychoanalyst. He devised new intervention strategies based more on phenomenological events than interpretive comments by the therapist. (Stevens, 1980). In developing his new therapeutic approach, Perls was strongly influenced by existential philosophy, with its emphasis on immediate experience; his experiences in theater and psychodrama; and body work as developed by Wilhelm Reich and others. Basic to Gestalt techniques is the notion that enhancing awareness promotes change, and the therapist's role is to facilitate that process. The techniques themselves rest on some very simple principles (Levitsky and Perls, 1970) and although these may initially seem far easier to understand than to utilize effectively, they can be added to a counselor's repertoire using concentrated but time limited training sessions.

An outstanding strength of Gestalt techniques is their usefulness in helping clients identify, describe, explore, and learn to appropriately express their feeling states. Historically, the more directly a particular therapeutic community was a descendent of the Synanon model, the more likely it was to foster the expression of emotion within a very narrow band of states. Synanon emphasized toughening up, functioning despite pain, converting feelings into activity. Confrontation or other expressions of anger were the only feeling states which were usually above suspicion. Sharing pain often was called self-pity; offering nurturance might be labeled as contracting; grieving viewed as self-indulgent. The softer, more tender areas, or emotionally complex themes, could not be explored in this setting (Deitch and Zweben, 1981).

Gestalt therapy is ideally suited to remedy these imbalances, and it is no accident that beginning about the middle 1970's it was increasingly incorporated into therapeutic communities. As programs gradually shifted their staffing pattern to include others of diverse backgrounds, who were not necessarily recovering addicts, other approaches began to filter in. This trend was largely welcomed by frustrated counselors who understood there were clinical tasks that they needed to do but did not know how to accomplish them. In addition, Gestalt work can produce some high drama, which was appealing, and its perceived anti-intellectual bias probably enhanced its acceptability as well.

Exploring Feelings: An Alternative to Confrontation

Most clients who have been involved with drugs for extended periods of time have some difficulties recognizing, describing, and expressing emotions appropriately. Those manifesting a pre-existing antisocial personality disorder will of course exhibit these characteristics, but they also commonly occur simply as a function of being caught in a drug dependence cycle for extended periods of time. It is so common for clients to immediately obliterate undesirable feelings that they need to learn or re-learn how to even recognize what they are experiencing. The Gestalt approach of asking the person simply to report what they notice or feel without trying to change it (referred to as monitoring the continuum of awareness), is powerfully effective in helping someone begin to explore his internal life. The therapist skilled in this process simply tracks or reflects without interpreting; the client learns to identify and describe internal states, vivid or subtle; the meta-message is that feelings just are; nothing needs to be done about them.

The continuum of awareness exercise can be done daily, with or without a facilitator. The payoff is enormous. By focusing in on the minute details of experience, the client learns to identify the subtle buildup of tensions which frequently lead to acting out behavior. This fosters the development of an "early warning system" and opens the possibility of choices in how feeling states are handled. Repeated work with the continuum of awareness will reveal what feeling states are the most difficult for the client to experience or report, and these can be given special attention. One of the major tasks in achieving a drug free life style is learning to deal with difficult feeling states, and this basic kind of therapeutic work offers a sound foundation.

Modifying Impulsivity

Certain Gestalt strategies can be effectively employed in individual or group sessions to work with the kind of situations which often lead to destructive acting out. In particular, the approach of asking a client to describe an event in the present tense, as if it were happening now, has wide applicability. Clients may be asked to describe in detail their experiences of craving, beginning hours or even days before an episode, as a means of identifying particular triggers of which the client may not be aware:

Cl: I am lying down in my room after work, and the next thing I knew I am on my way to the connection for some coke....

Th Let's go over it again. Relive your day for me, starting when you got home from work. Describe it in the present tense, as if it were happening now.

Cl: Well, I get home and I am feeling lousy.

Th: Lousy? Can you describe that for me, what it was that you are calling "lousy"?

Cl: Well, my wife is getting on my nerves, and I feel no one understands what I am trying to do in my life now, and I think about the buddies from the job I left and wonder how they are doing ....

Thus the therapist can help the client differentiate and begin to label various feeling states, in this case irritation, frustration, loneliness, and sadness. These can be later observed for their role in triggering drug hunger.

Not all episodes of craving have an identifiable trigger, and Gestalt therapy can be used to help clients master the experience and view it with some perspective as an experience which will pass. Just as the reader may readily produce salivation by imagining the smell, taste and feel of a juicy lemon, clients can show visible signs of arousal when reliving episodes in which they used or were tempted to use. The client may then be asked to describe, as if it were happening now, how he would like to handle that situation. The therapist instructs the client to take his time, imagine the events as vividly as possible, and report both actions and feelings. Active mastery through rehearsal in fantasy is a tool humans employ from early childhood on, and Gestalt techniques allow us to show clients how to use it both in sessions with a counselor or on their own. This tool is a great addition to other structured techniques in work on relapse prevention.

Dealing with Externalization

A fundamental tenet of Gestalt therapy is that the client changes by reclaiming the cast off parts of the self, and almost all the techniques facilitate this goal. Reliving experiences as if they were happening in the present tense enables the client to clarify choice points in the acting out process. Translating behaviors into interpersonal statements allows the client to examine the consequences of behaviors. For example, clients may translate the act of coming late to meetings in a variety of different ways:

"I'll do it on my timetable, not yours."

"I can't bear to sit around waiting for anyone."

"My time is more important than yours; you wait for me."

"I'm helpless to get here on time, need you to take charge of my time."

"I can't be expected to do as everyone else. I'm special."

Externalizations which take the form of selecting another in the community to act out the hidden parts of the self can be handled by asking the client to play out both sides of the conflict. For example, Jim and Jane repeatedly get into ritual bickering in groups, and no amount of confrontation in the group is able to resolve their impasse. Asking Jim to play both himself and Jane allows him to see the disowned part of himself which she represents, and once the issue is explored in these terms, the relationship between warring parties generally changes.

"One Day at a Time"

Gestalt work can be used to add deeper dimensions to the recovery philosophy of taking one day at a time. Frequently clients outrace themselves and react on the basis of what they fear will occur, rather than what they are in fact experiencing. Often it is not their actual discomfort, but their fear that it will become unbearable, that prevents them from working issues through productively. Repeatedly asking clients to compare what they are actually feeling with what they are imagining or fearing will happen gives them a much firmer reality basis on which to proceed.

Training Staff in Gestalt Techniques

The theoretical underpinnings of Gestalt techniques are very simple and very few, but mastering them can take varying lengths of time. They are easy to understand and sometimes hard to do. Imperfect understanding leads to the kind of mechanical application frequently seen during the 1970's when Gestalt enjoyed peak popularity. Currently, Gestalt Therapy has reached a level of maturity and is routinely offered in many graduate training programs. Institutes exist all over the United States and in Europe. A clinically experienced (though not necessarily credentialed) staff can learn much that is useful if weekly training sessions are provided for a period of 6-12 months. Supervision utilizing role plays are a key factor, as it is by definition a therapy that must be learned by experience. Participation as a client is of course desirable, but not always possible. Such engagement may be exceptionally useful for recovering staff with several years abstinence, as they are frequently very group-wise and skilled at handling interpersonal confrontation. For them, Gestalt opens up new possibilities for inner exploration.

In summary, Gestalt techniques offer a rich source of therapeutic interventions very well suited to the specific needs of recovering clients. They can be taught relatively easily to counselors with a wide range of professional training, provided the appropriate time commitments are made. They are a natural complement to interpersonal confrontation techniques are useful for a wide range of therapeutic tasks.

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CHAPTER 6

ADOLESCENT SERVICES & THE TC

PRELIMINARY CONSIDERATION ON ADOLESCENCE AND THE TC

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Adolescence and its attendant difficulties is one subject we can discuss at this international meeting with clear commonality. What is treatment, and more importantly, what is (or should be) adolescent therapeutic community treatment, may be subjects of less commonality and, as we shall see, maybe even serious debate. There are currently only two published chapters on therapeutic community treatment of the adolescent, in 1976 by Deitch & Zweben, and a N.I.D.A. monograph in 1985 by DeLeon & Deitch. Both should be read. Both show a shift and a growing appreciation of the complications with this population, and both describe psychological, psychodynamic and developmental issues.

Most of what adolescents experience, feel and must gain maturity over is common to all cultures -- American, European, Asian, Indian, African, etc. Yes, it is true that in one culture there may be greater latitude regarding, let's say, sex, than in another. Or some culture may have greater restriction than another regarding work, etc. But in all, adolescence is a time of testing limits and personal turbulence and is stressful for all -- the adolescent, the parents, and the culture.

Overall, the task of adolescence is to gain maturity, to take on a new adult (albeit young) role. What one faces in adolescence is complex; the task is immense. Let us look at a little of it. During this period the kid plunges through unprecedented change after change: hormones, weight, emotions, relationships, thinking, ideology and on and on. The relative stability of the preceding years is gone; coping skills are seriously challenged. Social aspirations and demands change almost daily. Decisions of seemingly major proportions must be made, invariably without enough experience or data. This new process involves forging not only a new sense of identity but, in fact, an altered identity. This new process of forging a new sense of identity is often done at least partly by rejecting values and identity given him and shared by the parents and, of course, by synthesizing the outcome of his/her identification with peers and other adults. Characterizations which were once accepted at face value during adolescence (such as the good child, serious, or frivolous) were for the most part expressed by parents, family and teachers identified with family. As peers become important, what may have been viewed as undesirable by parents can be found as interesting or desirable to peers. The serious student may be ostracized, and so forth. These feedback mechanisms and the need for separation from the "sticky" parental relationship may result in the following:

1) a crisis in the adolescent;

2) a profound sense of disappointment and devaluing;

3) lots of self-perceived inadequacies;

4) a profound sense of poor preparation by parents for the stress peers.

This may lead to further devaluing of ideas, values and behaviors which once resulted in positive behavior from parents. Suddenly overwhelming despair occurs. Adolescents want what they see themselves as not already being, overvaluing that which they are not and undervaluing that which they are. For a variety of reasons, there is immense denial of the process or many of the feelings. Usually the stress precipitates strong feelings which can't have clear focus. These un-understandable feelings cause even further stress, so things have to be done with urgency -- fast. An attempt to compensate and to be competent in a hurry often means taking actions which are inappropriate to meeting needs: sex instead of closeness, competition instead of mastery, and over-involvement in a limited role which gets recognition by peers, dopers, jocks, nerds, etc. Further, the adolescent within this naturally occurring time of crisis may not feel free to discuss or explore the nature of his/her experiences. The possible reasons for this are many. Let me just list some:

1) Role modeling by significant adults and the culture suggests no need for discomfort;

2) Lack of experience regarding talking about oneself;

3) Shame at disclosure;

4) Lack of self esteem;

5) Guilt concerning feelings and desires;

6) Perceptions that peers don't have the same problems; and finally,

7) conflicts with parents.

Without the ability to communicate, without relief of feelings, without relief of stress, the vulnerability is to shift toward inappropriate means. And in the culture there are drugs -- everywhere. So treating adolescents is becoming more popular, more sought after. Why?

1) Certainly our children are closer to us in adolescence, while still living with us. Clearly the culture shares this view, this memory.

2) The adult drug dependent addict/abuser is less sympathetic an image. It's a choice they made and considering the crime associated with drug addiction, the adult addict is often thought of as a thug, an enemy, or needing harsher consequences -- not treatment. But the kid, whose fault it that? And indeed, the question of fault, guilt, creates problems for the treaters.

3) Prevention efforts aimed at youth are under way.

4) Finally, adolescent treatment is now, in terms of ugly statistics, clearly necessary and clearly mandated.

Fact: 21 to 25 year olds and older report, on the average, drug use starting at age 17. In just five years that average has dropped so that our adolescent clients show, on the average, beginning drug use at age 11 to 13.

Fact: While marijuana use has finally reached a plateau (for now) at 40% of the U.S. population, it is the greatest of any industrialized nation on earth.

Fact: Cocaine use among youth has increased in the northeast, and by latest trends, in the west (California).

So, indeed, there are compelling reasons for both the need for and the popularity of adolescent treatment. But now let us pause for a moment. Let me remind you that just as what adolescents experience and how they behave is universal, there is also the fact that since time immemorial they have misbehaved, acted out, and throughout history often acted out with intoxicants. Junenal, in his third satire on the city of Rome, moans about the young hoodlums all steamed up on wine who started street fights for no reasons at all. St. Augustine, speaks of his own teen years, drinking and theft urged on not by poverty, but from a certain distaste for well-being. Wagner, the composer, talks of his adolescent involvement with violence, acting out rage in the surge of intoxification. Max Gorky talks of his own crime and thievery being condoned by elders whose own poverty viewed this as a way of keeping body and soul together.

Certainly the need to defy, to test limits, to push, to challenge is universal and consistent throughout the history of our species. As Religio Medici said, "Every man is not only himself, men are lived over again. The world is now as it was in ages past." Yet there are now real differences. For example, since time immemorial cultures have taken steps to curtail, to correct misbehavior. In adolescence these steps, until the last 50 years, would be perceived as highly punitive and horribly excessive -- ranging from imprisonment to being whipped, to solitary confinement, and, in some instances in every culture, death, albeit for different reasons ranging from theft to more serious crimes. The point is that for centuries all cultures have perceived the need to curtail, channel, direct and shape adolescents so that they can play roles perceived by the adults to be meaningful or at least not destructive. This is, of course, not easy in a rapidly changing world whose values and roles are at best currently confusing. To paraphrase Erickson, "When everything is expanding, it's hard to be integrating."

We in the therapeutic community represent a point of view, a position on values, on behavior, on the way one approaches life. That is, in order to unlearn bad, one must both learn good and do good. We, just be reviewing history, know the value of structured experiences for youth under the leadership of elders and teachers where discipline and challenge permit the productive channeling of young energy into productive and valued social roles. This was not considered treatment, it was considered preparation for life. Today I am at a preliminary point, a place where I need dialogue, feedback, discussion.

Fact: Data tells us it takes twice as long with adolescents to achieve improvement as it does with adults; twice as long for improvement. What the data does not tell us is, depending on what age, for how long subsequent to discharge?

Further, I ask you, what is treatment? Is it to achieve the cessation of the negative behavior? Or is it the cessation of negative behavior and the development of new, positive, socially valued and personally rewarding behavior? We all know the incorporation of a new real identity takes time. If we were in a different setting, no parent, no buyer would be startled if we told them, "To become a good skier, tennis player, musician, it's going to take 18 months to 2 years, or maybe longer, depending on native skills."

We certainly know that adolescents are moved at this age by the peer culture. We certainly know how pervasive drug use is in the adolescent peer culture. We certainly know that this period is loaded, as described, with stresses. And, finally, we know how easy it is to trigger behavior patterns biochemically with just one reintroduction of a drug! We know this. We further know that the TC can achieve more challenging demand and task performance than any dyadic or single parent structure. Just ask them. They say, "How did you get my kid to do that? He never would at home."

We certainly know that TC's can achieve more classroom participation and homework activity than any regular school. We certainly know that our task is cognitive growth, social skill growth, emotional growth and value growth. And that, in fact, if we are to achieve ending self destructive drug abuse, that is what is needed.

Now the problem is that everybody wants the adolescent drug use problem fixed fast and cheaply -- the magic bullet -- the very same type that was used on the mental health system. Just treat crises and do the rest in the streets. I remind you that's what made the nightmare that we live with today with the walking dead, freezing and slowly, brutally ending their days in every city in growing numbers across the country. What made the nightmare possible were practitioners and administrators, not just funders, who said they could do it and should do it.

Yes, parents want their children back quickly. The want the wound, the pain that must occur in treatment, to end and frequently end it prematurely. And, yes, parents want their kids' intoxicant use changed, but not their own. And how long does it take to armor a kid against that? And, yes, many family therapists view all adolescent drug use as a sign of family pathology, nothing more or less, and feel after short-term inpatient they can do the rest. And, yes, of course, the social service agencies desire that it be done less expensively, or more quickly. Funders say, "What about recovery houses?" and "Look at those short term hospital units" without examining the overall costs (social and others) of repeated, serial readmissions until the total exhaustion of insurance and personal finance resources.

But right now the data doesn't look like it can be done right in less that 18 months to perhaps three years. I need your thinking, considering what is occurring in the culture, to give these kids a chance, these kids whose level of personal, familial, school and social dysfunction requires a residential therapeutic community.

DAYTOP'S FULL SERVICE ADOLESCENT TREATMENT PROGRAM

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Recent developments within the drug abuse field, including the holding of a First Conference on Adolescent Treatment this year, and the revealing 1985 survey data from the New York Division of Substance Abuse Services, have highlighted the importance of adolescent treatment within the TC. This paper describes Daytop's comprehensive approach to adolescent treatment -- a full service adolescent treatment program which includes six ambulatory day treatment centers, an adolescent residential treatment center, and a separate short and long term reentry program.

In 1963, Daytop came into being as a pilot program treating hard-core heroin addicts. No distinction was then made between adolescents and adults, just as no distinction was made between minimal drug users and addicted users. A major shift occurred in the American drug revolution between the 70's and 80's that forced the TC to reexamine its policies and structures. The shift was basically one of population and drug preference. Polydrug abuse, not heroin addiction, became the dominant drug pattern, especially among the young. Daytop thus began to see a younger, more middle class population with more severe psychiatric profiles entering the therapeutic community. Many adolescents entering Daytop suffered from depression or were victims of incest or other forms of child abuse. A high percentage were children of alcoholics or drug abusing parents.

Development of Adolescent Ambulatory Care

TC's have been experiencing the impact of these shifts in American drug abuse patterns since the mid-70's. Because of the changes in drug use and style, we have had to adapt our treatment to the needs of younger more psychologically distressed, and family-alienated polydrug abusers.

Daytop's early experience with this population was a catalyst for our taking the major step of instituting an expansive day treatment program for drug-using adolescents.

By 1975, Daytop completed development of six adolescent ambulatory care facilities that now provide day treatment to a total of 370 adolescents in each of the five boroughs of New York City and Westchester County. Four hundred family members of these youngsters also actively participate in Daytop ambulatory programs.

The mandate of Daytop's outreach centers is to provide community-based day care for adolescents 13 to 19 who have minimal drug abuse problems. The centers work closely with the community to initiate prevention programs and other community service work such as Daytop's Elderly and School-Speakers Programs. Adolescents in our ambulatory program assist in community drug prevention efforts by discussing their personal drug histories and rehabilitation with school children their own age.

The peer principle, a critical recovery tool in treatment of these ambulatory center members, has proven equally successful when adapted to school prevention work. Adolescents in ambulatory treatment through the community service work of the centers benefit as much as they give as they experience the values and rewards of helping others. The ambulatory center-based Daytop CARES Program which provides meals and transportation to isolated and disabled elderly in Brooklyn and Queens is our proudest example of community service work benefiting both the community and our own adolescents.

Ambulatory Care: Programming and Philosophy

A typical Daytop ambulatory care stay averages 12 months. Length of stay varies, however, according to individual need. Whatever its duration, Daytop's ambulatory care for adolescents is participation by the adolescent in a highly structured day treatment environment which is divided into three segments:

1) Phase I is the integration of the new member into a positive peer support system that has proven to be one of the most powerful recovery tools of the therapeutic community.

2) Phase II focuses on in-depth psycho-social rebuilding. A foundation of drug-free behavioral stability and strong interpersonal and family relationships is established during this period.

3) Phase III concentrates on the social adaptation, educational, and vocational needs of members. Phase III activity emphasizes educational and vocational preparation; development of personal goals, and cultivation of social skills the adolescent will need outside of treatment.

Ambulatory care services include diagnostic screening and referral, physical examination, medical and dental treatment, positive peer support, group and individual therapy, family counseling, educational counseling and remedial course work, vocational counseling and placement, and recreational and cultural activities.

The hallmark of care provided with Daytop's Full Service Adolescent Programs is individualized treatment. Unlike programs with more limited resources, Daytop is able to follow up careful preliminary diagnostic screening, matching the adolescent's individual treatment needs. Adolescents are not automatically assigned to residential treatment since outpatient care is available. Nor are they assigned to long-term residential treatment because short-term inpatient care is available.

Each adolescent in Ambulatory Care is assigned to a clinical staff member who becomes his/her primary counselor. An individualized treatment plan is then drawn up for the adolescent who receives one-to-one counseling. They participate in group therapy and attend school taught by certified teachers within the outreach center who are supportive, yet challenge the adolescent to improve past academic performance. This is to ensure the youngster's successful return to school in the community and help him/her grow in self esteem. Adolescents pursue formal education in Daytop's outreach centers, perform assigned work functions as part of practical, applied work therapy and participate in the rich cultural activities of the facility.

Parental participation is essential for success in treatment. In an outpatient day treatment modality, uninvolved family members can very easily destroy hard-won clinical progress. Faster progress in treatment is almost always made when the family is involved in their child's treatment through supervised family counseling and actively participate in their own peer groups within the Family association.

Daytop has found that involvement of the family is a strong positive influence promoting adolescent outpatient recovery. Those who do not receive positive family support will often be precluded from participating in outpatient treatment since their prospect for success is limited. These youngsters will be referred to 24-hour residential care.

Day Treatment Versus Residential Treatment

There are significant differences in the make-up of residential versus ambulatory care, as there are also noteworthy differences between the adolescents participating in the two treatment modalities.

Ambulatory as opposed to residential clients, however, typically receive a different kind and degree of family support. These clients more often are individuals whose home environment is supportive of their treatment. TC residents very often have home lives that are seriously disturbed. These youngsters are more often orphaned, abused, or the children of chemically dependent parents.

Another feature distinguishing our residential programs is the admissions criteria. Criteria for admission to adolescent residential treatment is addiction. Criteria for admission to ambulatory care is drug use.

Drug use warranting admission to a day treatment program is use which causes the youngster problems at home, work or school. Drug behavior is also often associated with involvement with a negative peer group and with the criminal justice system. Addiction, as opposed to drug misuse, is more frequently physical or powerful psychological dependency.

Considerable controversy has recently been generated concerning residential treatment for chemically dependent adolescents. There is much debate concerning the question of what constitutes appropriate treatment for drug-taking adolescents. Issues of minors' civil rights and the effectiveness of various residential adolescent treatment programs have been specifically raised.

The philosophy, policies, and operational procedures of Daytop's adolescent program address many of the currently disputed issues. They are the following:

* Daytop will accept no adolescent for residential treatment until he/she has had appropriate diagnostic assessment and screening.

* There are no locked doors within Daytop's system of treatment.

* Daytop's ambulatory centers are specifically designed to assist the youthful drug experimenter who has already experienced home, work, school or legal problems because of drug use. Daytop will work with this individual to help him/her avoid falling into a permanent pattern of addiction.

* Daytop ambulatory centers act as the agency's prevention and community service arm, as well as treatment unit.

* Adolescent TC residents typically, but not always, use more drugs and use drugs more regularly than do ambulatory members. Many have been unsuccessful participants in day care programs who have been referred to residential care as a treatment of last resort.

* Many, but not all, adolescents referred to Daytop's residential program have stronger drug abuse patterns than day care members.

* The most important single reason for referring a client to Daytop's residential program is lack of a stable and supportive family environment.

Residential Treatment for Adolescents

Early experience in treating a mixed adult and adolescent residential population convinced us that a separate therapeutic community was needed to enable us to deliver more individualized and effective treatment to adolescent drug abusers. These residents, we discovered, have specific treatment needs because their life stage experience and existential problems and goals differ considerably from those of adults.

Thus, in 1977, when the number of adolescents seeking residential treatment justified the step, Daytop opened Millbrook, a 70-bed upstate new York residential treatment center. Adolescent programming developed for Millbrook expanded the services already offered by Daytop. The fact that most adolescents in ambulatory care come from a relatively stable home, and will return to the same after completing treatment, has proven to be the single most important factor distinguishing adolescents in ambulatory care from TC residents.

Daytop established Millbrook to provide adolescents with treatment that addressed their specific needs to maximize their recovery potential. Although there are similarities between adolescent and adult substance abusers, there are critical differences. We instituted policies several years prior to release of 1985 data from the New York State Division of Substance Abuse Services on adolescent chemical dependency treatment. It is interesting that philosophy and operating procedures initiated by Millbrook substantially reflect major recommendations made by the State Drug Agency. The policies paralleling the State Agency recommendations include the following:

1) Millbrook provides residential chemical dependency treatment for youth that is voluntary, drug-free, that supports abstinence from both alcohol and drugs, and that is staffed by a multi-disciplinary treatment team.

2) The basic premise behind Millbrook is the need to provide specialized treatment for adolescents whose treatment needs cannot be satisfactorily met in either adult residential treatment, or in existing ambulatory programs.

3) Millbrook admissions criteria overlap suggested New York State Division of Substance Abuse Services guidelines in that it is Millbrook general policy to accept into treatment adolescents whose psychological or physical dependency on drugs impair them in an important life sphere, i.e., home, school or work.

4) Millbrook, as DSAS independently recommends, looks to family stability as an important determinant of the length of the adolescent's treatment stay. Those who have a reliable family support system usually leave residential treatment sooner than those who lack this support.

As family support is associated with length of stay in residential treatment, so is it also associated with whether the adolescent will be accepted for ambulatory or residential treatment.

Differing drug histories, greater problem drinking and more distressed psychological profiles of chemically dependent adolescents, in particular, point to a need for separate instead of combined adult and adolescent residential treatment. Profiles of chemically dependent adolescents more often indicate a need for comprehensive mental health services, alcohol education, and total abstinence, particularly for high risk children of substance abusers. Daytop has responded to these specialized needs with a program of intensive alcohol education for adolescent TC residents; a total abstinence ethos, and a specialized TC staff including certified teachers, sports directors, art therapists, etc.

Since a large proportion of adolescents will return to their natural or substitute family upon graduation, family therapy plays a more central role in their treatment. Preparation of both the adolescent and parents for realignment into a healthier family system at the end of treatment is one of the most critical aspects of his/her treatment.

Another difference between the adult and adolescent resident is the primary importance of the educational component in the treatment of the adolescent. The adult focuses more strongly on the work-related concerns especially critical during the reentry process.

Formal Education within the Adolescent Therapeutic Community

Millbrook offers residents excellent formal education specifically adapted to the TC structure at junior, high school and college levels. These educational programs attempt to teach more, however, than do traditional schools. Education is important in its own right but is also important clinically as adolescents gain increased self-esteem as a natural consequence of growing academic competence.

In addition to mastering academic subject matter, the adolescents learn values, a responsible concern for self and others, the rewards of creative work, cooperation and teamwork in learning, effective self expression, abstract reasoning and problem solving skills, and respect for self, others, the learning process, and intellectual disciplines mastered.

Behavior modification is a dynamic part of Millbrook's educational programming, as it is also an important aspect of other clinical programming. The adolescent students are rewarded for cooperation, a positive attitude toward learning, good study habits, good effort, and good academic achievement. Learning is not solely academic, but takes place on three basic levels -- academic, psychological, and philosophic.

The three levels interact synergistically to benefit the adolescent. Thus, the well-motivated responsible adolescent experiencing the satisfaction of academic achievement enjoys the complimentary bonus of increased self-esteem and general psychological well-being.

Millbrook strongly emphasizes education since adolescent substance abuse is significantly correlated with poor school performance and minimal study. The correlation suggests that the intensive formal education in therapeutic communities can lead to not only educational gains but also to gains in the adolescent's sense of self-worth that will support abstinence. Within Millbrook, as within Daytop's other TC's, therapeutic learning is primary and most critical. Our experience with formal education within the adolescent TC, however, clearly establishes the worth of academic learning as a therapeutic tool.

An important part of formal education at Millbrook which diverges sharply from traditional American educational practice is adaptation of TC values to academic learning. The residents work together cooperatively as a learning team. Unproductive academic competitiveness, which is often encouraged in the educational system outside the TC, is replaced by the peer process model which is the TC's central therapeutic tool. Use of peer tutors, peer role modeling and peer cooperation are stressed.

The pre-college course work provides appropriate education at the academic readiness level of the individual. It also serves as a bridge to other educational opportunities available within and external to the therapeutic community.

Daytop Miniversity is one of these opportunities. Through the Miniversity, selected older Millbrook residents are able to obtain undergraduate college credit applicable to the Baccalaureate Degree while still undergoing treatment at Daytop. Adolescents, like other Daytop residents who participate in the Miniversity program, typically show significant gains in self-concept including establishment of a more positive, reality-based self-image.

Vocational Training

Although vocational training is less emphasized within Millbrook than in the adult therapeutic community, residents are pretested for vocational aptitude at the start of their stay and later participate in two 14-week courses in one of the three following vocational areas: micro-computer/word processing, furniture restoration/rebuilding, or culinary work.

Vocational counselors work closely with the residents to help them shape and attain objectives. The vocational counselors also cooperate with the New York State Office of Vocational Rehabilitation staff to provide the adolescent with more comprehensive vocational skills training than the TC alone can provide.

Beyond any of its other functions, Millbrook is most basically a caring community and substitute family for adolescents displaced from the two most critical human institutions -- family and community. Millbrook serves also as a symbolic halfway house bridging the initially great distance between the adolescent drug abuser and his/her healthy participation in society.

I believe that Millbrook's greatest healing strength and the basis of its treatment success is the quality and kind of second chance family that it offers to adolescents who have been abandoned physically or psychologically, and who are usually, themselves, self-abandoned and despairing.

To achieve the objective of serving as substitute family and caring community, Millbrook is structured so that each resident becomes a brother or sister to every other resident with each resident helping all others to grow into caring and responsible adulthood. A staff member who is assigned to each adolescent as his/her primary counselor provides individual and group counseling on a daily basis while also serving as a positive role model and parent figure.

In addition to participation in Family Milieu Therapy, all Millbrook residents receive the following formal family services:

* family assessment on intake

* family therapy

* counseling for individual family members

* crisis intervention and family counseling

All clients receive medical and psychiatric care as needed, acquire values education, attend daily house activities structured to provide a sense of community and enhanced individual identity, and participate in recreational activities including art and dance therapy, team sports and group outings. All Millbrook residents also participate in group therapy in each of the following group modalities:

- encounter groups
- static groups
- topical groups
- peer confrontation groups
- pre-request and leave request groups
- health, hygiene and sexuality groups
- extended groups
- marathons

Specific educational and vocational services which are a standard part of Millbrook treatment include:

Stage I: Assessment - Vocational/Educational Levels: Vocational/Educational intake evaluation, standardized math and reading tests for placement in school program. High School Equivalency program, life skills training through the New York State Office of Vocational Rehabilitation, Vocational Training through the New York State Office of Vocational Rehabilitation, Vocational/Educational counseling for college placement, seminars and topic oriented workshops.

Stage II: Evaluation - Vocational/Educational Needs: Assessment by Certified Rehabilitation Counselor, retesting, successful attainment of educational goals appropriate to client's age, completion of Life Skills Training Program, successful completion of remedial course work necessary for placement in college.

Stage III: Placement - Vocational/Educational Programs: Attendance at school/vocational workshops, vocational/educational counseling, New York State Office of Vocational Rehabilitation referrals.

Work therapy, a form of behavior modification utilized in the TC, is structured so that residents receive progressively more responsible work assignments and are held personally accountable to all other members of the TC for successful performance of job functions.

Work therapy like other aspects of behavior modification therapy employed at Millbrook, emphasizes changing the maladjusted behavior as its primary goal. Clinical work to uncover and repair underlying causes behind the negative behavior is valued but will follow later. The basic premise of Millbrook's reward and denial behavior modification approach is that the adolescent will learn more healthy behaviors, and more positive values if there are always positive and negative consequences attendant on behavior.

Millbrook was established essentially because the concept of the therapeutic community as a dependable, highly structured and involved second chance family cannot find full expression outside of 24-hour residential treatment. This is the most important factor distinguishing Daytop residential from ambulatory treatment.

Adolescent Reentry Component

As staff began to see that adolescents have specialized reentry needs which differ from those of adult residential clients, a reentry program was added to Daytop's other adolescent services to accommodate these needs.

A specialized adolescent reentry unit was also developed as a response to the changing charade of entering clients and of their parents. The program thus had to adapt to the needs of younger clients who required supervision not available in their homes. Daytop has also had to adapt to the adolescents' parents who often were children of the flower power and drug experimentation times of the 60's. Grown into adulthood, the parents often have not been able to maintain two-parent family or to end their own drug use.

Daytop established its adolescent reentry unit so that adolescents in the therapeutic community are not forced to return directly to an unhealthy family setting diluting treatment gains and setting a tone for ultimate treatment failure.

Adolescents with a healthier family support system were seen to benefit from a short-term residential reentry period cushioning the cultural shock of reintegration into the community. The peer support offered by the program has proven valuable in cushioning reintegration into the community and also in achieving the social, academic, and vocational goals of the adolescents in the unit.

Concurrent with opening of the reentry unit, we established a procedure requiring evaluation of all adolescents completing residential treatment to determine whether the individual would benefit more from a reentry stay or immediate transfer to a Daytop ambulatory unit.

Although the decision to rotate a resident to reentry or to an ambulatory center is made on an individual basis, there are generally three kinds of adolescent residents who are rotated from Millbrook:

1) Those in need of short term reentry after which time they will be transferred to an ambulatory center for aftercare and back to their parental home;

2) "Standard" adolescent residential clients who are rotated to reentry as part of an orderly progression of treatment which will in time lead to graduation; and

3) The very hardest to treat and to service individuals who are in need of long-term reentry due to their age and/or inability to ever return to living with their family of origin due to either family disorganization, drug abuse, or to physical and mental abuse of the child.

While Daytop's adult reentry program is more strongly focused on return to work, the reentry program has as its prime focus successful return of the adolescent to the family and community school system. The two reentry programs also differ in that the length of an adolescent's stay in reentry is strongly influenced by degree of family involvement in his/her treatment. Reentry residents whose parents actively participate in treatment generally leave reentry sooner than adolescents whose families are less involved. The length of an adult's reentry stay, however, is primarily determined by individual, not family, factors.

Adolescent reentry is also distinguished from adults by the fact that they generally stay in residential care for a shorter period of time. Adolescents in reentry require greater structure, support and supervision than adult clients who are older and capable of greater independence. Adolescent reentry is more highly structured. They still have their treatment supervised by one primary staff member and participate in a more structured clinical and cultural program.

Another factor distinguishing adolescents from adult reentry is the need for placement that many adolescent reentry members have. Adults are expected to leave the therapeutic community and lead an independent life. Many adolescents who complete the adolescent reentry program, however, do not have a viable home to return to or are too young to live independently.

Conclusion

We who have dared to assume the role of substitute parents to the youngsters in our care find that with great intensity they want to learn if we are only the nurturers they know or whether we are also active and instrumental figures. Are we potent and reliable enough to successfully protect their interest in an uncertain world? As we monitor their growth and development, so do they monitor ours.

The first question posed is whether we in the therapeutic community have the requisites and creativity to make whatever changes are needed to keep programs alive and well financially and effective as treatment tools.

Can we cut whatever ties we must with our social service history?

Can we become possessive to the extent that the survival of the therapeutic community depends on this and yet ensure that treatment, our true business, is not compromised?

Are we capable of building bridges of successful cooperation with alcohol agencies to successfully treat a common problem?

Can we, by cooperating with alcohol agencies, establish dual licensing and funding initiatives that will bring us closer to success in attacking one grave problem?

We must be successful at all of these tasks. For it is only from the basis of this success that we may ensure a future for the therapeutic community and expeditiously fulfill the honorable, enormous, and responsible role that we have assumed as guardians for adolescent children in treatment within the therapeutic community.

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ADOLESCENT SUBSTANCE ABUSERS IN THE TC: TREATMENT OUTCOMES

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ABSTRACT

Post treatment outcomes are reported for a sample of a 1974 cohort of adolescent and adult substance abusers in a traditional therapeutic community. Data are presented both for voluntary and legally referred clients. The main findings reveal that a) legal referrals were proportionately higher among adolescents; b) regardless of age or legal status, the entire sample showed a considerable degree of criminal involvement; c) as expected, younger clients and voluntary referrals reveal less criminality, although juvenile history of crime was significantly highest among legally referred adolescents (under 19 years of age); d) age did not significantly relate to post-treatment outcome. Success rates were statistically similar for adolescents and adults. However, legally referred adolescents who dropped out of treatment yielded fewer favorable outcomes. Nevertheless, the evidence indicates that the TC exerts a positive impact on these more recalcitrant groups of adolescents.

INTRODUCTION

Substantial literature points to the effectiveness of the therapeutic community (TC) approach in rehabilitating substance abusers (see recent reviews by Bale, 1979; Brook and Whitehead, 1980; De Leon, 1984; De Leon and Rosenthal, 1979; Sells, 1979). Significant improvements occur on separate outcome variables (drug use, criminality and employment) and on composite indices for measuring individual success (e.g., De Leon, et al., 1982). With few exceptions, followup studies report a positive relationship between time in program and post treatment outcome status (see Figure 1). Generally, these findings have been obtained on program-based studies of individual TCs (e.g., Barr and Antes, 1981; De Leon, 1984; Holland, 1982). However, they have been corroborated in larger scale externally based followup studies of various modalities that include therapeutic communities (e.g., Simpson and Sells, 1982).

The recent decade has witnessed a marked increase in adolescent substance abuse. Despite a slowing of this trend in the last three years, the prevalence and the range of youthful drug use is greater, and the age of first use is lower than that seen ten years ago.

Adolescents comprise approximately 20-30% of admissions to drug-free residential settings, such as TCs (CODAP, 1979). Almost a third of these are referred to treatment through the Criminal (juvenile) Justice System.

However, relatively little is known about the efficacy of different treatment modalities for these adolescent clients and less is understood about the effectiveness of treatment for adolescent substance abusers who have been involved in the criminal justice system. For example, a recent volume reviewing youth drug abuse contains only two studies of treatment effectiveness (Beschner and Friedman, 1979).

In these studies conclusions about treatment effectiveness for the adolescent remains somewhat unclear for several reasons. First, the adolescent samples followed were drawn from different treatment modalities and program. Program effectiveness may vary particularly within the therapeutic community modality. Differences in clients served, philosophy, resources and clinical and management experiences, as well as success criteria, all contribute to program variability. Second, one study did not include post treatment outcomes. Additionally, there were other methodological weaknesses which render the findings from this effort somewhat tentative. Third, the other study (i.e. DARP) did not provide a single composite index of individual success with respect to age differences. This is important for traditional therapeutic communities whose primary treatment aim is a global change reflected in elimination of antisocial behavior, illicit drug abuser as well as enhancement of productivity. Fourth, and perhaps most importantly, these outcome studies have not focused on adolescents who were legally involved or referred to treatment from the juvenile justice system.

The above considerations shaped the general purpose and design of the present research. A brief description is provided of the criminal background characteristics of two subgroups of adults and adolescents, volunteers and those legally referred to treatment in a traditional therapeutic community. Post treatment outcomes for these groups were obtained with a composite success index of individual change.

METHOD

The Traditional TC

There are more than 500 federally supported, drug free residential settings in the United States (Holland, 1982). Not all of these are therapeutic communities (TCs) and, among the subset of those termed

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There are more than 500 federally supported, drug free residential settings in the United States (Holland, 1982). Not all of these are therapeutic communities (TCs) and, among the subset of those termed therapeutic communities, approximately 25% are of the traditional long term variety, such as Phoenix House.

These programs are similar in planned duration of stay (15-24 months), in staffing pattern, and in rehabilitative regime, although they differed as to size and client demography. Clinical staff are a mixture of degreed and nondegreed professionals. Often, the majority of the clinical management staff are ex-offenders and ex-addict/substance abusers who themselves were rehabilitated in the TC programs. Support staff generally consist of degreed professionals in health services, fiscal administration, legal, vocational-educational and family counseling. The clients include criminal offenders and the socially displaced, adults and adolescents whose primary presenting problem is substance abuse.

The perspective of the traditional TC on drug abuse and its recovery has been described in other writings (De Leon, 1981; De Leon, 1984; De Leon and Beschner, 1977; De Leon and Rosenthal, 1979; Kaufman and De Leon, 1978). Fundamental to the TC approach is the necessity for a total 24-hour residential community impact to modify lifelong destructive patterns of behavior. The basic goal is to effect a complete change in the lifestyle: abstinence from illicit drug use, elimination of antisocial behavior, development of employable skills.

Residents move through explicit phases that are sequenced to provide incremental degrees of learning, both psychological and social. Generally, there are three main phases: early (0-3 months), primary treatment (4-12 months), and reentry (13-24 months). The daily regime is structured to keep the resident fully involved in a variety of work, educational, therapeutic and recreational activities. Some key treatment components include group therapy, individual counseling, tutorial learning sessions, remedial and formal education classes, and client job functions.

Adolescents and adults in traditional TCs undergo the same basic regime in treatment process. However, there are modifications in the TC approach which acknowledged distinctions among substance abusers which have been identified primarily through clinical observations and some research (see for example, De Leon and Deitch, 1984; Holland and Griffen, 1983). These primarily emphasized the normal developmental needs of adolescents. For example, the importance of education, family involvement, guiding social and sexual role identity, etc. A further account of the therapeutic community approach for the adolescent is provided elsewhere (De Leon and Deitch, 1984).

The Sample

A full description of the followup study is contained elsewhere (De Leon, 1984). This section briefly summarizes the essential methodological elements.

The 1974 cohort (N=424) consisted of male and female dropouts (N=371) and graduates (N=53) who were mainly black, and 19-26 years of age. Fifty-three percent were primarily involved with amphetamines or barbiturates (primary "other"), and 5 percent claimed no primary drug of abuse.

The 1974 dropouts were a 37% sample of the entire residential population randomly drawn from six continuous time in program (TIP) groups (less than 1, 1-4, 5-8, 9-12, 13-16, and 17+ months). With the exception of the largest (17+) group, each TIP group was of similar size but represented a varying percentage of the TIP proportions of the residential population. Graduates (N=53) were a 52% sample of those who completed the program in 1974-75.

Criminal Profile. Since legal referral was a variable in this study the criminal profile of the entire sample was analyzed by age and legal status. Criminal involvement is significantly higher among older clients regardless of those with a legal status. The clients over 27 reveal significantly higher total arrests, total convictions, drug arrests and drug convictions when compared with the two groups under 27 years old which are generally similar. These age differences are more pronounced for the oldest clients with a legal status whose criminality was significantly higher than all other subgroups by age or entry status; Juvenile criminality, in terms of total arrests and age of first arrest is worse among the younger clients, particularly those with a legal status.

not described. The survey contained over 225 items, binary or scaled rating, that focused upon four main temporal periods: 1) Background - family, social, personal, drug and criminal history in the years prior to Phoenix (lifetime); 2) Pre-Phoenix - month by month tracing of life activities in the year before entry into Phoenix; 3) Phoenix experience - the client's expectation and perception of treatment benefits, significant treatment influences, staff and peer relations, and reasons for termination; 4) Post-Phoenix - month by month tracing of life activities, e.g., drug use, drug and other treatments, criminality, employment, and social and personal relations across all the years of followup.

Entry Status. . There were two classifications of entry status: 1) legal status-clients referred to treatment directly through the criminal or juvenile justice system, typically including individuals who are probated, paroled, or otherwise court mandated to treatment; and 2) non-legally referred (voluntary status) -- those clients whose source of referral did not directly involved the criminal or juvenile system.

There are caveats concerning these entry status classifications. Legal status clients may actually choose treatment on a voluntary basis since this may be offered as an option for them. Conversely, voluntary clients may seek treatment under existing or anticipated legal pressure, such as a court case, the presence of warrants, etc. Thus, the classification is employed to grossly distinguish two groups of clients by their primary route of referral.

Similarly, the labels do not precisely identify differences in motivation for treatment nor do they necessarily correlate with the clients' perception of legal pressure. Legally referred clients may vary in the degree to which they experienced anxiety, pressure or fear of legal consequences. Later analyses will assess motivation or experienced pressure to change among both legally referred and non-legal referrals.

A minority of the followup sample entered Phoenix House with a legal status. Significantly more graduates were legally referred than dropouts. Legal status decreased linearly and significantly with age and, reciprocally, the percentage of volunteers increased with age (Figure 2).

Success Rates by Age and Legal Status

Success, in the TC, is a shorthand term describing the essential clinical goals of prosocial behavior and freedom from drugs. Thus individual social adjustment was measured with three composite indices derived from 16 separate variables in the domains of criminality, drug use, and employment.

The Criminal Index (CrimDX). If there was at least one episode of criminal engagement, arrest or at least one week spent in jail during any month of observation, the CrimDX was scored for the entire year and for all cumulative years.

The Drug Index (DrugDX). A DrugDX was scored for all clients if there was a) any use of any opioid (heroin, methadone, dilaudid, or other opioid) irrespective of the client's primary drug pretreatment ç or b) any use of the primary drug, opioid or nonopioid. For clients who reported no primary drug pretreatment, a DrugDX was also scored if there was any use of glue, hallucinogens, hypnotics, or weekly use of marijuana or alcohol, or use of other nonopioids single or in combination, at least 3 times in 1 month. Again, a DrugDX in any month resulted in a DrugDX for the entire year and for all cumulative years.

The Success Index. Weighted combinations of the CrimDX and DrugDX placed the client on a 4-point scale of favorable status. Criminality was judged more negative than drug use in the rating. Employment was excluded from the 4-point success index for empirical reasons. A 12-point index correlated above +0.90 with the 4-point scale, indicating that this addition did not significantly change the client's relative status. The 4-point success index was defined as follows:

Success #4, Most Favorable Status: No occurrence of a CrimDX and no occurrence of a DrugDX through all months of observation.

Success #3, Favorable Status: No occurrence of a CrimDX through all months of observation, but at least one occurrence of a DrugDX.

Success #2, Unfavorable Status: No occurrence of a DrugDX through all months of observation, but at least one occurrence of a CrimDX.

Success #1, Most Unfavorable Status: At least one occurrence of both a CrimDX and a DrugDX either separately or together in any month of observation.

There are temporal requirements that entered in the Success Index. The lowest Success Index in any year was the index for all cumulative years. Conversely, a best Success Index (#4) had to be maintained for all cumulative years. An index less than best was included in the results irrespective of the minimum requirement for time out of program (TOP). However, best successes were excluded if they could not meet the TOP requirement. These criteria represent Phoenix's austere requirements for success. However, they generally accord with the conservative view of clinical success in other traditional TCs.

Time at risk (TAR) was defined as TOP minus months in jail. TAR entered into the construction of the success index. Jail time was automatically scored as a CrimDX. Also, a DrugDX was scored if the client

Table 1

Success at 2 Years Followup: Age and Legal Status (a) Males

		Legal		Voluntary		Totals	
		N	%	N	%	N	%
<19 Years							
Success	4 (b)	6	33.3	3	30.0	9	32.1
	3	1	5.6	4	40.0	5	17.9
	2	2	11.1	0	0.0	2	7.1
	1	9	50.0	3	30.0	12	42.9
10-26 Years							
Success	4	19	39.6	26	44.8	45	42.4
	3	6	12.5	14	24.1	20	18.9
	2	8	16.7	5	8.6	13	12.3
	1	15	31.2	13	22.4	28	26.4
27+ Years							
Success	4	4	30.8	15	33.3	19	32.8
	3	1	7.7	11	24.4	12	20.7
	2	3	23.1	5	11.1	8	13.8
	1	5	38.5	14	31.1	19	32.8
Totals							
Success	4	29	36.7	44	38.9	73	38.0
	3	8	10.1	29	25.7	37	19.3
	2	13	16.5	10	8.8	23	12.0
	1	29	36.7	30	26.5	59	30.7

(a) Percents may not add to 100.0 due to rounding.

(b) Success 4: Most favorable (no crime and no drug use)
3: Favorable (drug use, but no crime)
2: Unfavorable (crime, but no drug use)
1: Least favorable (crime and drug use)

(c) Positive change from pre-treatment distribution of success index is statistically significant. The actual proportion of individuals who changed is more clearly shown when absolute success status is ignored. Almost 84% of the sample had the lowest success index (Index 1) for the year prior to treatment. Positive change over pre-treatment levels occurred in almost 60% of the sample and was significant by age and legal status with the exception of the youngest legally referred clients. They showed the smallest reduction in change for clients with the lowest category.

failed the drug use criteria while in jail. Time spent in other drug treatment settings, however, was considered a risk, although some investigators have argued otherwise.

RESULTS

Success Rates. Table 1 shows the distribution of the success index by age and legal status. The data on females are excluded since there were few women under 19 years old with a legal status. The results in Table 1 may be summarized as follows. The overall success rate (percentage of Index 4) for the sample is 38.0% and did not differ significantly by age (last column) or legal status (last row). However, clients in the middle age range (19-26 years of age) yielded more successes, regardless of legal status.

When dropouts and graduates are separated, differences appear, particularly by legal status. Legal referrals were significantly higher among graduates (57.1% vs. 34.9%), a difference that occurred at every age; and graduates yield a significantly higher success rate than dropouts (66.7% vs. 32.7%). This graduate/dropout difference persisted across age and legal status.

Among dropouts, however, outcome appears to be related to both legal status and age, although differences were not statistically significant. Higher success rates were obtained for the clients 19-26 years old (42.3%) when compared to the youngest (22.7%) and the oldest clients (28.9%); among the latter two groups, more success occurred for voluntary clients.

Some Correlates of Success

The relationship between success rates, legal status, age and other client correlates were further examined through hierarchical and regression analyses. In these, predictor variables were entered in a fixed order corresponding to a theoretical conception of their hierarchical position. The first set of variables was race/ethnicity, primary drug of abuse and age at entry; legal status on admission was entered next followed by an age-legal status interaction variable. (Interaction variables in linear regression models have been challenged by other investigators.) The last entries were pretreatment success index and time in program. The latter was assumed to be correlated with treatment influences and deliberately entered last to evaluate its contribution after the effects of the other variables were removed. There were no exclusions based on risk factors since few clients were confined in jails or hospitals during the 2 post-treatment years. Regressions were carried out for the male dropouts only since the inclusion of the graduates would have biased the weight of the time in program variable.

Higher success through two years of followup was related to primary opioid abusers, voluntary clients, and longer time in treatment. Notably, the age-legal status interaction variable was not significant in the regressions.

Based upon the significant regression findings, the 4-point distribution was examined univariately by primary drug of abuse, age at entry and legal status. Among dropouts, opioid abusers showed significantly more best successes than non-opioid abusers (46.9% vs. 10.9%), a difference that persisted across age and legal status. Regardless of primary drug, a higher proportion of least favorable outcomes occurred among the younger clients with a legal status. However, the oldest non-opioid abusers with a legal status also contained a high proportion with least favorable outcomes.

Among graduates, success rates were uniformly high by age, legal status and primary drug. Notably, all of the young graduates who were primary opioid abusers with a legal status achieved best success status. When dropouts and graduates are pooled, the success rates for the youngest opioid abusers with a legal status elevates and exceeds those for the clients over 19. Thus, the relatively higher proportion of least favorable outcomes for the under 19 year old clients is confined to the dropouts with a legal status.

Success and Time in Program. The regression results indicate that time in program remained the most significant predictor of successful outcome. Prediction of time in program itself has been examined in multiple regression studies reported elsewhere (De Leon, 1983). In these, age, legal status or race did not significantly relate to retention, although primary opioid abusers yielded significantly longer days in treatment than primary non-opioid abusers. Notably, univariate analyses revealed no significant differences in mean days in treatment by legal status within each age group. Thus, although success overall increases with retention in treatment, the relatively high proportion of least favorable outcomes among the youngest dropouts did not relate to their time in program.

In summary, favorable outcomes were significantly higher for graduates, primary opioid abusers and voluntary clients. Age overall did not relate to favorable outcome. However, those in the middle age range had more successes and least favorable outcomes were more frequent among the youngest clients with a legal status regardless of primary drug. This finding was true for dropouts only. The inclusion of graduates reduced the proportion of poor outcomes and significantly elevated the success rates for the legally referred young opioid abuser.

Finally, among the dropouts, the relationship between time in program and success is prominent among the opioid abusers particularly in the middle age levels. Outcomes for the oldest and youngest clients are less clearly related to length of treatment; in particular, the relatively higher proportion of least favorable outcomes among the youngest dropouts with a legal status is not related to their length of stay in treatment.

COMMENT

Favorable outcomes were more frequent among volunteers, however, evidence indicates that the impact of treatment does not appear to be substantially different by entry status: a) best success rates were not statistically different but the distribution was significantly more favorable for the volunteers; b) although successful, a considerable number of volunteers had criminal histories that were not significantly different from legally referred clients; c) conversely, over 70% of the graduates entered treatment with a legal status most of whom achieved and maintained best success levels.

Success rates were significantly higher for primary opioid abusers regardless of legal status or age. As reported elsewhere, this primary drug difference in part reflected the rather austere criteria for success in TCs which prohibited use of opioids or a non-opioid primary. Relatively few marijuana and alcohol abusers achieved abstinence from their primary drug. Thus, most could not be classified as best successes although many had eliminated their criminal activity and/or showed significant reductions in the frequency of use of their primary drug (see De Leon, 1984).

Figure I

PHOENIX HOUSE
AGE AND LEGAL STATUS
(1974 Followup Cohort)

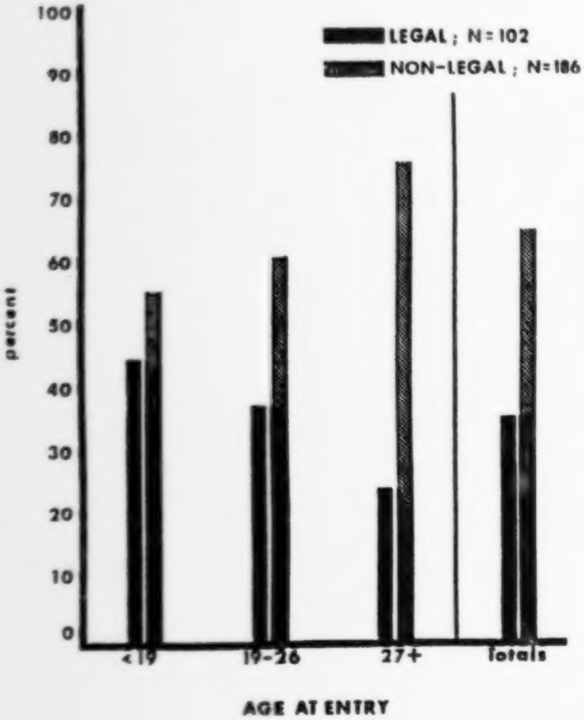
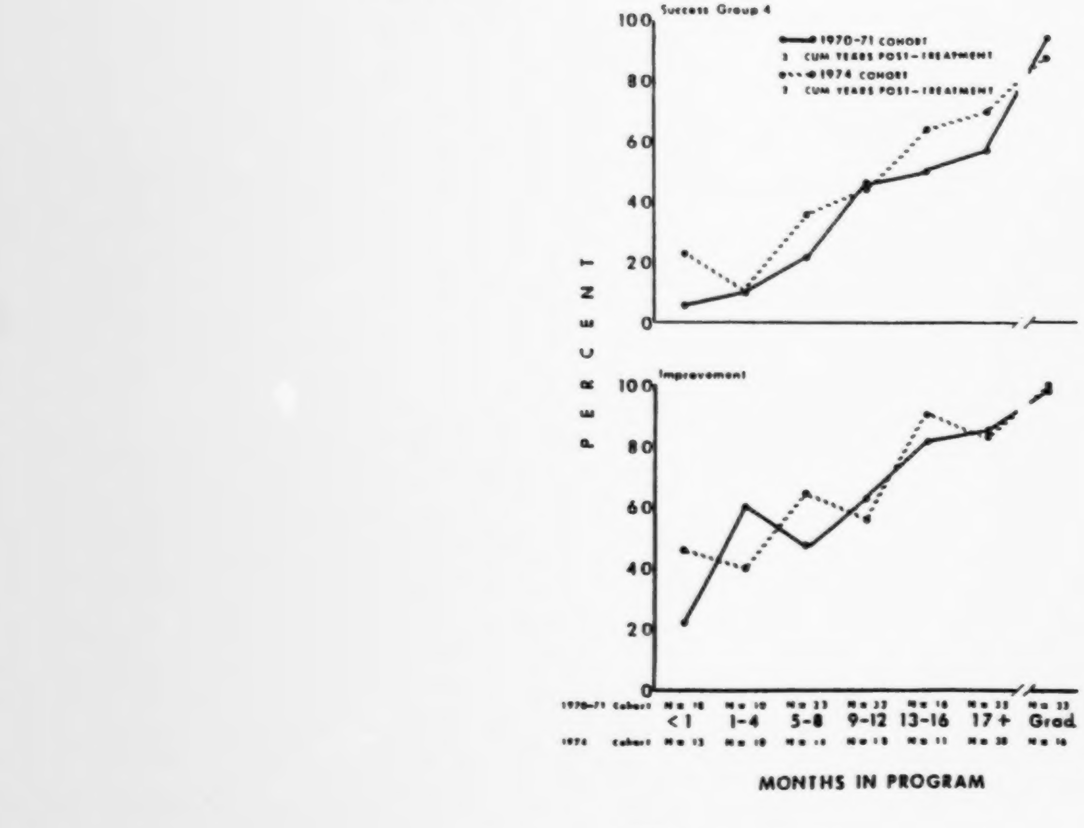


Figure 2



Age did not significantly relate to outcome. Best success rates were statistically similar across age and the regression analysis indicated that there was no interaction between age and entry status with respect to outcome. However, legally referred adolescents yielded less favorable outcomes, a result which is not yet well understood. Although time in program was the most significant predictor of success, outcomes among the young dropouts did not relate to their length of stay in treatment. Moreover, among all graduates, the proportion of legal referrals and success rates is significantly higher than dropouts.

Thus, there appears to be a subgroup of adolescent dropouts whose criminal background is similar to graduates but who continue to use drugs and commit crime regardless of their time in treatment. Other characteristics which may differentiate this group remain to be investigated.

Notwithstanding the above, the present adolescent findings are particularly impressive in light of the following points. First, the therapeutic community serves a more difficult or recalcitrant group of adolescents in comparison to outpatient settings. This is evident in the criminal profile results (not reported) for both the legally referred and voluntary clients whose criminal histories are significantly worse than those reported in the national survey sample of adolescent clients in federal drug treatment systems. Second, there is the common view that antisocial behavior and drug involvement tends to accelerate in the period from adolescence to young adulthood and tends to weaken in older clients; these age changes are presumably maturational. In the present findings, the better success rates among the older clients may in part reflect these hypothesized age related effects, although the relationship between time in program and success rates among clients over 19 points clearly to the influence of treatment.

Thus, the evidence indicates a significant treatment impact upon the adolescent clients in the sample. Best success rates, although lower, did not differ significantly from older clients; and the improvement from pre-treatment level in global status was significant, indicating a measurable reduction in their overall criminality and drug use.

Finally, the present findings firmly establish a relationship between residency in the TC and client status at followup. Conclusions concerning treatment effectiveness, however, must be interpreted in light of methodological and other considerations. For example, the validity of inferences about treatment is limited by the lack of control groups. The followup sample may be self selected to seek, remain in and benefit from treatment. Statistical regression and behavioral cycle hypotheses could be advanced to explain the observed changes over time; similar other possible influences in client status are drug treatments after Phoenix, social climate factors concerning criminal enforcement and drug traffic, as well as maturation and other as yet undetected client factors. As discussed elsewhere, these factors did not appear significant relative to the impact of treatment in the TC (De Leon, 1984).

CONCLUSION

Overall, the findings indicate that adolescent outcomes are not unlike those of adults. Under the rigorous outcome criteria employed in TCs, the success and improvement rates obtained are impressive regardless of age or legal status, although more graduates, volunteers, long term dropouts and primary opioid abusers yielded favorable outcomes. Fewer successes were obtained among the more antisocial young clients who were referred with a legal status. Nevertheless, evidence indicates that the TC exerts a considerable impact on this most recalcitrant group of adolescents.

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THE CHILD ABUSE - DELINQUENCY CONNECTION: IMPLICATIONS FOR JUDICIAL AND TREATMENT PERSONNEL

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This paper reports on the author's research on the relationship between child abuse and delinquency, summarizes the larger abuse-delinquency literature, and discusses policy aspects of the relationship.

Sandberg's Research

The project, entitled "The Role of Child Abuse in Delinquency and Juvenile Court Decision-Making" and funded by the National Center on Child Abuse and Neglect, was conducted in 1982-83 by a multidisciplinary team of research and direct service people. The project examined four issues: a) the prevalence of abuse/neglect among 150 delinquents referred to Odyssey House in Hampton, New Hampshire over the period 1974-82; b) whether specific kinds of abuse consistently lead to specific kinds of later delinquency; c) psychiatric implications of the abuse-delinquency relationship; and d) the feasibility of amending state delinquency codes to require an assessment for child abuse/neglect as an integral part of the pre-disposition social history.

Stages 1 and 2 were empirical in nature and carried out under the leadership of Dr. Murray Straus. The major findings were as follows:

1) Of the 150 delinquents (defined as a criminal offense if committed by an adult), 98 or 66% were identified as abused or neglected based on Odyssey House's medical/psychiatric records. Only residents whose maltreatment was pervasive and sufficient to warrant a finding of same under a preponderance of the evidence standard were coded "abused." "Neglect" and "emotional abuse" were construed very narrowly by the project.

2) 61% of the 99 boys studied and 75% of the 51 girls had been abused.

3) Physical abuse was by far the most common (53 of 99 boys, 32 of 51 girls). Next most common was sexual abuse (4 of 99 boys, 19 of 51 girls).

4) Over half of the abused group (54 of 98) experienced multiple abuse, meaning the same type of abuse at the hands of more than one parent and/or two or more different types of abuse.

5) The mean age of onset of abuse was seven (7), with only 10% of the abused group experiencing abuse that commenced in adolescence.

6) The average severity of physical abuse was 2.4 (out of 3), indicating that on the average the physically abused children in the study were very seriously assaulted.

7) Only a small number of the 98 abused youth had been identified as abused prior to entering treatment under court order.

8) Families of the abused group were typically multi-problem families, e.g. almost half of the abused youth had parents who were violent to one another, double the rate for families of non-abused children.

9) No significant relationship was found between specific types of abuse and specific types of later delinquency.

10) No significant relationship was found between specific types of abuse and later assaultive behavior, including no correlation between severe abuse and violent delinquency.

11) Members of the abused group were not involved in more crimes or more serious crimes than members of the non-abused group.

Following the empirical analysis of the 150 Odyssey House residents, then (10) additional youth were selected for case histories developed by the program's psychiatrists, Drs. Rowen Hochstedler and Judianne Densen-Gerber. The intent was to pursue analysis of the child abuse-delinquency relationship along psychiatric rather than sociological lines which thus far has not advanced much beyond prevalency rates.

These psychiatric members of the research team identified several paramount concerns associated with the child abuse-delinquency relationship. One, of all the problems commonly associated with delinquent youth, child abuse has the most devastating development impact. Two, the physically abused children reveal major confusion over nurturance and violence in interpersonal relationships, and the sexually abused children have major confusion over what is nurturance and what is sexual exploitation. The latter may explain why the three (3) case histories involving childhood sexual abuse also feature later teen prostitution. Three, minor delinquency does not necessarily mean an absence of abuse, rage, and the potential for violence. And four, most of the case histories involve youth with matricidal/patricidal feelings.

Both psychiatrists articulated the view that identification and remediation of child abuse are essential prerequisites for many delinquents to avoid later criminality and/or other dysfunction in adulthood.

The fourth and last stage of the project involved an extensive assessment of the juvenile justice system nationally to determine the presence of any "systems" responses to the child abuse factor in delinquency cases. Only two were found (dicta by the West Virginia Supreme Court suggesting that juvenile trial courts should look for abuse histories prior to certain dispositions, and New York's conversion law which enables a judge to convert a proceeding for delinquency or CHINS offense into one for abuse). Given such a low level of awareness, the project urged that much more attention be given to the subject.

The legal members of the team also concluded it was legally defensible (and desirable) for each state to amend its delinquency code to require abuse probes prior to disposition. Only in this manner are courts apt to uniformly give attention to a critical factor in the lives of many delinquents.

In concluding its analysis, the project recommended that the abuse factor not be considered until after the adjudicatory phase of delinquency proceeding, to dispel any concerns that giving more attention to the abuse will result in excusing delinquent behavior. Moreover, project members emphasized that courts should always carry out a twofold responsibility to juvenile offenders: hold them accountable for illegal behavior and ensure that treatment referrals are made on the basis of specific rather than general information.

The Larger Child Abuse-Delinquency Research Literature

The Sandberg research is the most recent in a small number of studies going back to the early 1970's, nearly all of which show a high incidence of child abuse among delinquent populations. Three of the more often cited studies are briefly noted here.

1) Dr. Weston's Philadelphia study (unpublished) of 100 juvenile offenders, of which 82 were abused as children. 43 recall being knocked out by their parents.

2) Hopkins' Denver study (also unpublished) of 100 juvenile delinquents, of which 84 were abused before entering school. 92 were bruised, lacerated or fractured by a parent within a year and a half prior to their arrest for delinquency.

3) Jose Alfaro's New York study (published in Exploring the Relationship between Child Abuse and Delinquency, editors R. Hunter and Y. Walker) of over 5,000 children whose families were reported for suspected abuse in the 1950's, and 2,000 children who were reported for delinquency or status offenses in the 1970's. Children in the former group were traced ahead to learn of later contacts for delinquency, the latter traced backwards to learn of earlier contacts with a child protection agency. With both samples, Alfaro found contact rates as high as 50% in some counties.

A detailed analysis of the child abuse-delinquency literature was carried out in 1984 by Professor James Garbarino of Pennsylvania State University (Child Maltreatment and Juvenile Delinquency: What Are the Links?, unpublished). His conclusions include:

1) A significant relationship does exist between child abuse and delinquency, especially when the former is defined broadly and the latter narrowly;

2) How there two phenomenon relate, including causation elements, has yet to be determined;

3) Comparing studies is problematic due to researchers using differing definitions of "abuse" and "delinquency" or failing to define them;

4) Most of the studies are limited by the absence of a control group;

5) Data on the relationship between physical abuse and violent delinquency is sparse, but findings (mainly Alfaro's) indicate an association may be present;

6) "Our meager knowledge in this area is a promise of future understanding. Our ignorance is a challenge to researchers and policy makers alike."

Policy Considerations of the Abuse-Delinquency Relationship

Notwithstanding our "meager knowledge" concerning more complex aspects of the relationship, we know the single most important thing about the child abuse-delinquency connection: namely, there is one and it is significant. This alone is sufficient to compel major activity within the policy and direct service communities. The remainder of this paper will briefly identify several such activities the author believes are especially needed.

Amend delinquency codes. Only in this manner will juvenile courts uniformly become aware of the child abuse factor among many young offenders. Wyoming now has such a statute which requires predisposition reports to include information on several state-of-the-art factors, including child abuse, learning disabilities, and physical impairments. There is no guarantee courts will make informed dispositions with this information, yet its presence makes appropriate placements more likely. It will also lessen any tendencies to overuse reform schools.

Train mental health workers. This includes therapeutic communities whose programs feature outpatient or inpatient units for adolescent offenders. Specifically, staffs to be effective today require training in such things as proper diagnostic/assessment protocol, generic stages of treatment for abused persons, and defusing rage. Similarly, given a high rate of learning disabilities among delinquents, programs also need to have a special education capability. Both problems necessitate family therapy skills as well as an aftercare program.

Earlier interventions. Although therapeutic communities working with adolescent and adult offenders will always be assured of an ample client case load, it behooves us to become involved in other intervention points along the acting-out continuum. Particularly important are efforts within the schools, as early as the elementary school years. To be more effective early intervenors, schools will need the assistance of courts and therapeutic communities, with their years of experience in dealing with behavioral problem youth. In light of the growing awareness about the abuse factor in acting-out, we need to stand behind educators in the effort to identify and remediate abuse as early as possible.

Conclusion

There are recent encouraging signs that the child abuse-delinquency issue is moving from the research community into the policy arena. In addition to Wyoming's 1984 amendment, the states of Delaware and Colorado are currently developing policy initiatives. Moreover, many key legislators have recently been briefed on the issue through seminars organized by the National Conference of State Legislatures in Denver. Especially noteworthy is the current effort by the American Bar Association to bring greater awareness of the issue to the legal community.

Beyond these undertakings and the policy initiatives called for here, it will eventually be necessary to add new curriculum to our schools of law, medicine, social work and psychology. Adolescent care has historically received too little attention in the United States, but the persistent problems of delinquency and child abuse, in particular, appear to be stimulating significant new attention to acting-out children.

THE THERAPEUTIC COMMUNITY AS A MODEL FOR EFFECTIVE ADOLESCENT LEARNING

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Treating young people during adolescence has always held special interest and challenge for the therapeutic field. Not only is adolescence a period of drastic physiological, social, and psychological change, but it is also a period of critical influence on the unleashing of the potentialities of young people for maximum self-realization and productivity in later life. Practically half of mental growth occurs during adolescence. In the therapeutic community field we not only have the opportunity but the obligation to provide an environment that facilitates self-actualization of the adolescent through development of cognitive, social, emotional and physical skills. It is my belief that the therapeutic community model accomplishes this task with adolescents in a way that no educational institution or other treatment model can.

Let us look first at the theoretical reasons why the therapeutic community model works educationally for adolescents. Throughout this discussions, keep in mind this premise: I believe adolescents have special needs within the therapeutic community and should not be treated as mini-adults.

I have compiled a list of elements which help explain the process through which a person learns. As I go through the elements of learning theory, I will discuss the relevant elements of the therapeutic community model in an effort to emphasize why the therapeutic community model works effectively with adolescents. This learning theory model was developed through the research of Dr. Stanchfield, Professor, Occidental College, Los Angeles.

Motivation

I believe motivation is essential and central to learning. I view motivation as: 1) energizing, activating and sensitizing the organism toward certain stimuli; 2) directing behavior toward certain goals; and 3) reinforcing behavior that is effective in the attainment of desired goals. In a therapeutic community, factors that should be used to motivate learning are:

1. *Contagion.* The mental health and attitude of the counselors, therapists, teachers, group leaders is extremely influential, or contagious on the client. The power of role-modeling is an essential element in motivating adolescents to change.

2. *Expectancy.* Expecting clients to change, learn and achieve goals successfully has a substantial effect on attaining the desired behavior from the client. This is the self-fulfilling prophecy. Clients tend to behave the way we expect them to behave. In the therapeutic community model, the community or group expectations are especially powerful with adolescents.

3. *Effectance.* The ability of an organism to cope with a test affects his learning of that task. It is safe to say that an adolescent will reach new heights as a result of success in meeting challenges and will reach new lows as a result of continuous failure. Success is important as an element of motivation particularly as it leads to the development of a positive self-concept and hence to further success and further motivation. There are two types of success, the first being vertical success. This is the concept that success at one level will lead to success at a higher level. This dictates that learning experiences be presented in a sequential, developmental hierarchy. In a therapeutic community, this sequence is very evident in the phase or level systems of program completion. It is important to set the stage for client success by providing readiness exercises, setting clear-cut, short-term and attainable goals, pointing to evidence of progress and not expecting too much too soon.

The second type of success is horizontal success. This is the concept that people who have success in one area will have success in other areas. It's a spread effect that success plays on the person's self-esteem and ability to meet new challenges. I have witnessed this repeatedly in the therapeutic community model. A client who is experiencing success in his job function will experience success in school, or success in school leads to success in groups which leads to success in family therapy and so on. Conversely, failure also has a spread effect.

4. *Interests.* Interests are acquired as a result of satisfying experiences and, once established, tend to perpetuate themselves as long as they are effective from the standpoint of the individual's goals and purposes. One of the therapeutic community's primary responsibilities is to foster new purposes, new motives and new interests. To do so, the therapeutic community must relate therapeutic community experience to the adolescent's motives and purposes. There must be relevance and purpose to the learning experience. Developmentally, the adolescent has the capacity to grow in ability to concentrate, to reason, to gain insight, to generalize and to use imagination. They find satisfaction in intellectual activity, becoming more creative, imaginative and precise in their work. It is therefore effective and necessary to build and foster the adolescent's field of life experiences and interests. For example, it is ineffective to teach adolescents the

concept of integrity without relating it to the role honesty plays in their present life experience in their family, their peer groups, in school.

5. *Visibility.* One method to motivate change is to make dominant or visible in the community the behavior or goal you wish to attain. This means lifting up success, however small, of clients, praising positive behavior, reinforcing positiveness through phase advancements, honors, awards, charts, and basically recognizing achievement in some concrete manner. For some reason, counselors sometimes feel this is too juvenile and that the type of clients we have in therapeutic communities would not respond. Yet, I have experienced the opposite. Recognition and rewards are very powerful in effecting change. Extrinsic rewards are just as important as intrinsic rewards. For example, how many of us work for merely the intrinsic satisfaction of helping others achieve self-actualization? We may fool others into thinking this is why we work so hard, but the reality of that very powerful extrinsic reward called a paycheck is a monthly dose of motivation.

6. *Involvement.* It is not enough for a person to simply learn about things, he needs to become involved in the learning process. A client is more motivated when actively involved in the learning process. This means simply presenting information and requiring clients to regurgitate that information back to us, will not lead to effective learning by the clients. Involving the client intellectually, emotionally, physically and socially in the learning is very effective. Group encounters is an example of this concept in action. Client A who verbally expresses (with emotional and social emphasis) a specific behavior in Client B that needs to be changed is actually learning and reinforcing that behavior change within himself. Client A will have greater retention of the lesson than Client B.

Thus, in summary, the element of motivation includes the factors of contagion, effectance, expectancy, interests, visibility and involvement.

Readiness

The second element of learning theory is Readiness. Readiness is a broad concept covering a wide variety of factors which may be grouped as follows:

1. *Physiological factors.* Behavior cannot take place unless there is sufficient maturation of the sense organs, the central nervous system, the muscles and other physiological equipment. Very basic to this factor is the physiological influence drug use has on learning. It was reported in an article from the New England Journal of Medicine in 1983 that marijuana intoxification impaired intellectual performance, including the ability to repeat in forward and backward order a succession of digits, to make a succession of repeated subtractions mentally, to form concepts, to speak coherently and to transfer material from immediate to longer term memory storage. Therefore a drug-free therapeutic community has an advantage over the public school system in the sense that it has enhanced the physiological readiness of an adolescent to learn by eliminating the physical impairment of drug use.

2. *Psychological factors.* The individual must have the proper motivation, a positive self-concept, and relative freedom from devastating emotional conflicts and other psychological impediments to be ready to learn. Within the definition of psychological factors of readiness, the therapeutic community has real strength. Because of the structured, consistent, and sequential nature of the therapeutic community program, adolescents are in an extremely psychologically safe environment. Within this psychological safety, adolescents are able to make significant gains academically, socially, emotionally and with their families. The clients we see in the therapeutic community are able to make these gains more quickly and I believe with greater retention than those with similar dysfunction in the regular school system, out-patient treatment or short-term residential treatment.

3. *Experiential factors.* With the exception of the learning that stems from inborn response tendencies, learning can take place only on the basis of previously learned skills and concepts. This reinforces the use of hierarchical systems in the therapeutic community. Learning experiences must be provided in a sequential, developmental hierarchy of skills.

Practice and Drill

Practice of a skill does not insure learning but it does allow for the time for learning to take place. Practice gives the learner an opportunity to use his knowledge in his climb to new heights. Systematic practice allows the learner to grasp gross meaning during the initial trials and to grasp more refined and subtle meanings on subsequent trials. In complex materials, practice enables the learner to test the correctness of his insights from the first trial, to clarify ambiguity, and to correct misconceptions. To be effective, practice and drill should be meaningful and purposeful, specific, varied, frequent and distributed, supervised, fairly uninterrupted, reinforced and capable of active involvement by the learner.

Relating this element of learning theory to the therapeutic community is quite simple. The therapeutic community involves treatment of the adolescent as a whole. Opportunity to practice knowledge occurs continuously because the therapeutic community is a microcosm of the adolescent's life. We must remember to provide practice not only of intellectual knowledge, but also social skills, emotional development, physical skills and family relations. The day to day activities of the therapeutic community should be structured for the sole purpose of providing practice of lifeskills and knowledge.

Retention

The goal of all learning is for that learning to be retained. The extent of retention depends on such factors as functionality of the material learned, and the interrelatedness of the components, the meaningfulness to the learner's background, intelligence and motivation, the adequacy of mastery and the nature of the learning process. To encourage retention several factors should be taken into consideration:

1. *Association cues.* The more associative cues a learner can form, the more likely he is to retain what he has learned. This can be enhanced by teaching the concept in a variety of settings so that it is associated with a variety of cues.

2. *Degree of Mastery.* All indications are that the crucial variable in retention is the degree of original learning. Good retention revolves around good learning. We must teach for mastery.

3. *Review.* Review is probably one of the best means of maintaining retention above a given level. Review brings about deeper understandings and new insights into relationships that are more functional as well as more permanent than the original learning.

4. *Set or Intent to Remember.* Retention is facilitated by having the client learn with full expectation of being tested on the material. Intent to remember is related to motivation which makes for maximum retention. If learning is to be retained, it cannot be learned passively. The learner, intent on remembering, is actively involved in the learning process.

To maximize retention, these elements should be considered when structuring learning experiences in the therapeutic community.

Reinforcement

Thorndike's "Law of Effect" states that, other things being equal, those responses followed by satisfying aftereffects tend to be learned. Inherent in the therapeutic community model are behavior modification techniques, designed to provide systematic reinforcement for good behavior, so that misbehavior is gradually eliminated through extinction and through displacement by positive alternatives.

What is also a potential danger in the therapeutic community is the overuse of aversion techniques. There is a need and benefit to have the therapeutic community environment stable, consistent and controlled to some extent. However, there is also a danger in the therapeutic community becoming rigid, autocratic and punitive. We need to be continually sensitive to the fact that petty rules, arbitrary regulations that serve no purpose, impossible standards, one-way communication, repressive discipline and other forms of rigid bureaucratic nonsense simply dehumanize and alienate those we are attempting to treat.

Transfer

Life is predicated on the assumption that what we learn on one occasion will facilitate our dealing with related situations in the future. Since, in the therapeutic community, we cannot possibly teach all that a client will need to know, we do need to teach for transfer of learning so the client will be able to adapt to new situations. Helping the client develop a cognitive structure of clear and stable foundations with an appropriate level of abstraction, generality and inclusiveness to which new learnings and experience can anchor is essential. A key to what learning will be transferred is the relevance of the material to the learner. Sometimes too, we have to assist clients in focusing what is relevant and meaningful. Especially in real-life situations, the main point is often obscured by nonessentials. And finally, the level at which the client has achieved self-actualization is crucial in determining whether transfer will occur. The client who has a positive attitude toward the experiences he encounters, a constructive self-concept, relative freedom from anxiety and maximum openness to new experiences will be the client who can approach new situations with eagerness and confidence in his ability to meet life's demands.

My purpose in describing these eight elements of learning theory was to highlight the factors in a therapeutic community that provide optimum potential for learning.

In as much as adolescent substance abuse is a disorder of the whole person, effective treatment must focus on a global change of the individual. Therefore, in treating adolescent substance abusers, attention must be given to the social, emotional, intellectual, psychological, physical and family relations components of learning. No one aspect can be ignored. The therapeutic community model of learning can provide a tremendous potential for unleashing the opportunities for young people to maximize self-actualization and productivity in later life.

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NEW MORNING FOR COLOMBIAN YOUTH

Dra. Josefina Gallardo de Parejo

Fundacion Nuevo Amanecer
Bogota, Colombia

The foundation Nuevo Amanecer (New Morning) is located in Bogota, Colombia. It is a non-profit organization with the aim of rehabilitating and re-educating adolescent drug users, ages 16 - 18 years old, who have had problems with the criminal justice system. The goal is to provide treatment and rehabilitation services so that these youths can play leadership roles in combating drug addiction among Colombian youth. The foundation consists of people of good will and proven moral character who volunteer professional and personal services to help realize our objectives.

The program was started on July 19, 1984 in order to provide services to families who didn't have sufficient resources to take their children to private programs where fees were too high. Nuevo Amanecer took as its role model the Hogares Crea International in Puerto Rico, directed by its founder, the sociologist Juan Jose Garcia, whose generous and spontaneous collaboration was greatly appreciated in helping our staff to learn administrative techniques, fund-raising, scientific and practical knowledge about how to help rehabilitate drug abusers.

Subsequently, in search of new information and experiences, we were invited by the State Department, through the United States Embassy in Colombia, to visit drug programs in Virginia, Washington D.C., Maryland and New York. We found some interesting programs, but couldn't put these to practice in Colombia, because of the differences in our youth, although we could identify with the struggle to free adolescents from such a threatening problem as drug abuse.

Later, we got in touch with Juan Corelli, founder of CEIS (Centro Italiano de Solidaridad) in Italy, a great and humane man, who cordially invited us to participate in the 8th World Conference of Therapeutic Communities in Rome. It was there I met Don Mario Picchi, who generously opened the doors of his TC, offering us the training we needed to apply TC principles and concepts to our program, Nuevo Amanecer, with magnificent results.

The first phase of treatment at Nuevo Amanecer is the "Acogida", whose basic object is to shelter the person in crisis, resolve immediate conflicts, and establish the motivation to change by providing an understanding of the necessity to change. Also, the purpose of this orientation phase is to begin the reconstruction of the family system, and give spiritual assistance. The Acogida can handle more than 120 juveniles, but currently holds 70, who voluntarily take part in this phase of the program, accompanied by their parents.

The Therapeutic Community, which is the second phase of the prog- ram, emphasizes work, responsibility, discipline and communication skills. Here the adolescents are exposed to the TC dynamics. This facility has the capacity for 80 residents. It is air-conditioned, well-equipped and ready to receive youths who come from the Acogida, who have been evaluated by a Committee of Professionals, including doctors, psychiatrists, social workers, and psychologists. In a month or two, we will have our first residents in this phase of treatment.

Nuevo Amanecer is sustained by the generosity of private institu- tions, CEIS, the Colombian Institute of Family Well-Being, the U.S. Embassy in Columbia, the constant and continuous support of volunteers, and with the parents and family members of residents who make up the Parent's Association.

The Director of the Institute of Family Well-Being has agreed to collaborate to establish a rural TC for youth, since there is enough land in Cajica to do this. Because we are getting such support, we expect that by the time we attend the 10th World Conference next year, that there will be numerous TCs in Colombia, established with the help of ex-addicts, families, young adult groups and various authorities, to which adolescent drug abusers will be diverted to, and from which young adult leaders will be trained.

Free-base cocaine is the most common drug among consumers. It may contain sulfuric acid, chloroform, kerosene and gasoline. It may cause anxiety, irrationality and paranoia. Gradually sexual desire is lost, causing frigidity and impotence. Emotional blockages, autism, and other irreversible nervous system disorders which destroy the personality can result.

Dependency upon the drug will make its users do anything in order to obtain it, including stealing (first of all in their own family), and both feminine and masculine prostitution. Since the drug makes studying or working impossible, it is understandable that many adolescent addicts are converted overnight into delinquency. Freebasing also produces a physical dependency. It is consumed from the lowest grades in school to the university. Although it is considered new on the market, freebase cocaine has been consumed in Colombia for 9 years, and this is why we are applying all our strength towards helping the youth of our country.

SPORTS, DRUG ABUSE AND TEENAGERS

Delvin Williams

Pros for Kids
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Pros for Kids represents a new approach to the problem of curbing drug and alcohol abuse among teenagers. It is the inspiration of former San Francisco 49er running back Delvin Williams. Forced to an early retirement through drug problems, Williams has now dedicated his life to substance abuse prevention. His philosophy in forming Pros for Kids is to use celebrated professional and amateur athletes as role models for kids. Through a balanced program of athletic and academic endeavors, Pros for Kids translates many of the disciplines necessary in becoming a good athlete into the personal life style necessary to become a good citizen.

Since its inception three years ago, the organization has grown phenomenally and now handles three major balanced projects directed against drug and alcohol abuse; Pro Camps, TAP (Teen Alternative Program), and a Special Activities Program.

Pro Camps is a series of day camps set up in the summer months around the Bay Area. Here, celebrity athletes work with the kids on both athletic and academic programs strongly aimed toward curbing substance abuse.

The Teen Alternative Program, TAP, is a self-governing group of youngsters established to promote positive alternatives to drug and alcohol abuse. They publish a monthly newsletter and hold various educational activities.

Special Activities of Pros for Kids takes the message to all youngsters through such forums as school assemblies, conferences and community presentations. As with Pro Camps, celebrity athletes are used for these presentations.

BALANCE is the major theme used by athletes in working with the kids. A balanced approach to both academic and athletic endeavors is strongly stressed. Using their own personal experiences, pro athletes transfer to young people the need for dedication, clear goals, mental and physical preparation and a strong desire to succeed. The theme BALANCE has become the cornerstone of Pros for Kids. Its six major steps are:

1) How to be a winner. Preparation.

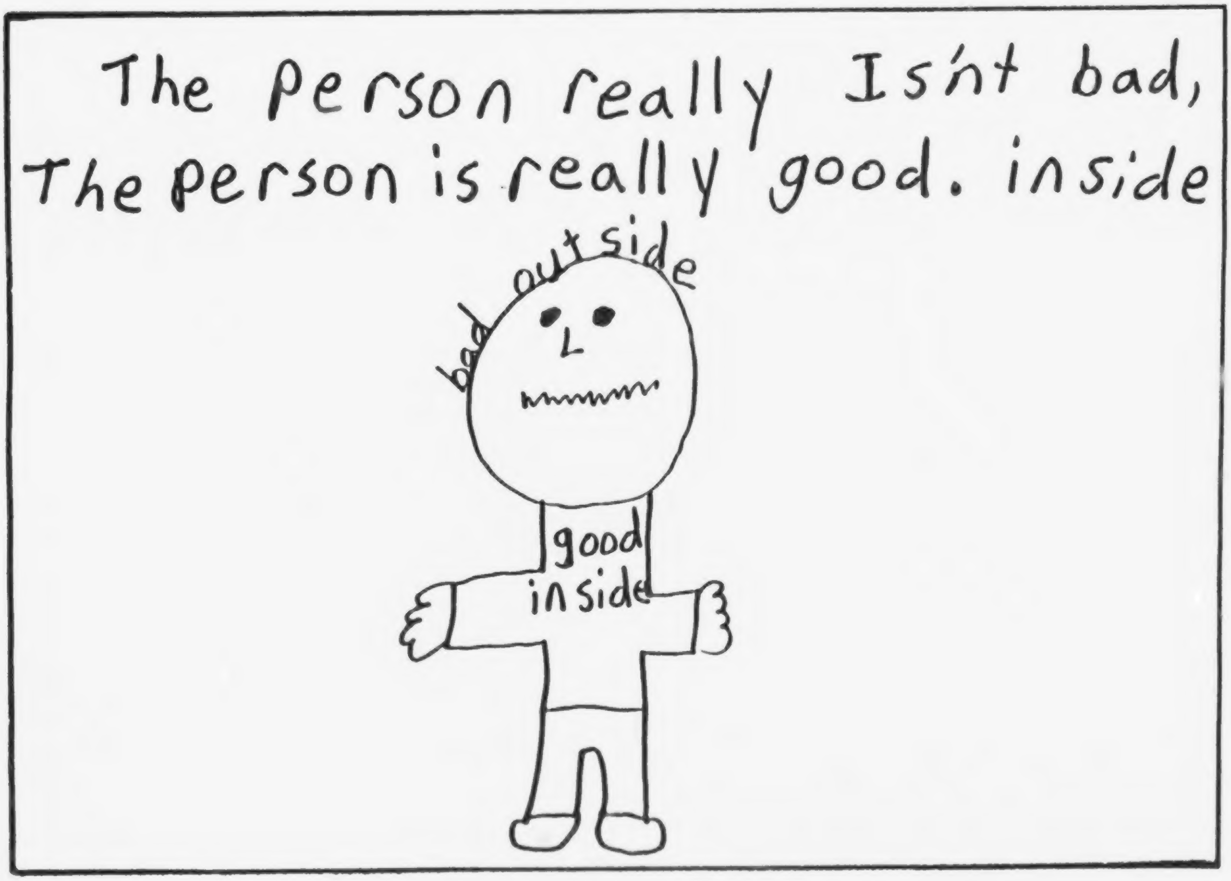
2) Overcome barriers to excellence. Basic techniques.

3) Realize full abilities. Conditioning.

4) Go for the gold. Plan of attack.

5) Be a winner. Execution.

6) Maintain perseverance. Evaluation.


The person really Isn't bad,
The person is really good. inside
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CHAPTER 7

DRUG ABUSE & THE CRIMINAL JUSTICE SYSTEM

SOME CHARACTERISTICS OF THE SOCIAL STRUCTURE & SOCIAL ORGANIZATION OF THERAPEUTIC COMMUNITIES

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Cross-comparisons of the Social Structure of "Therapeutic Communities" and Traditional Correctional Institutions: Prisons and Hospitals

In order to fully understand the structure and organization of therapeutic communities, it is useful to cross-compare their organization with the traditional institutions devoted to resocializing deviants. Most traditional therapeutic structures have a two-tier caste system of organization. There are the "doctors and the "patients"; the "correctional officers" and the "prisoners"; the "healers" and the "sick." This caste-like division is based on the premise that if the patient follows his doctor-therapist's instructions, he will get well. Most correctional organizations reflect this type of medical model.

In a prison or a hospital, the assumption is that if the prisoner-patient follows the rules of the institution, and properly interacts with his therapist, he will change and become a better citizen who can function more effectively in the larger society.

These caste-like we-they medical model institutions have been dramatically changed by the innovative "therapeutic community." This point may be best made for our purposes by the following closer examination of the differences between the social structure of TCs and traditional institutions for deviant behavior change.

Most offenders have a close familiarity with traditional "correctional" systems. He has learned how to do time in reformatories, prisons, jails, mental hospitals, addict hospitals. Even at his first arrest, he is already equipped with a set of attitudes for handling encounters with society's law enforcers. He learns the proper set of attitudes and responses on the streets, and these are reinforced in the institution.

The "bad guys" are the cops, squares (non-addicts), judges, jailers and administrators. On the right side of the fence are "righteous dope fiends" and "stand-up guys." The offender learns quickly to trust the "right guys" and to hate and distrust the correctional officials.

In the traditional institution, if he's a right guy, he lives according to inmate rules. He believes "Thou shall not squeal," engages in petty larceny and gets some homosexual kicks from the prison punks. If he is a "solid" member of the inmate in-group, he cons the staff members whenever he can. They are the enemy inside the walls who represent the enemy (square society) outside the walls of the institution.

Almost all members of hospital and prison officialdom are stereotyped by the inmate code--at best as inept, at worst as proper targets of extreme rebellious hatred. For most inmates, they are objects to be manipulated for quick release, or they are tricks to beat for small scores to relieve the boredom and monotony of custody. In the chess game of manipulation, the institution's officials are pawns. This inmate code tends to confirm and reinforce criminal-addict ethics and behavior. The code reinforces lying, manipulation and sociopathic behavior.

In contrast, the offender entering a TC is usually baffled by what he encounters in this different social system. Everyone is a "right guy," including the administrators, most of whom were in his position at one time. If he tries to play his usual institutional games, he is laughed at. He has difficulty having the officials in a TC, because they are people like himself, or people who have experienced his position in life.

If he wants to break out (a common subject of conversation in most institutions), he is invited to get lost by the TC staff. At every turn he discovers new responses to old situations and, most important, other people who know how he feels and understand him. Instead of receiving a callous reaction, he is told, "I remember how I felt when I first got here," and this is often followed by as detailed description of the precise feeling he is experiencing at the time. This is often disconcerting and frightening, because it is a new and strange situation. Yet, at the same time, the sight of others like himself who "made it" gives him confidence. He has role-models, people he can emulate, unlike the therapists he has known in most custodial situations.

In a TC he finds a new society. He encounters understanding and affection from people who have had life experiences similar to his own. He finds a community with which he can identify, people toward whom he can express the best human emotions that are in him, rather than the worst. He finds friends who will assist him when he begins to deviate or fall short of what he has set out to do--to develop and mature. In the new society of the TC, he finds a vehicle for expressing his best human qualities and potentialities.

Caste and Stratification

The inmate subculture develops within any custodial institution, producing a "we-they" attitude between the professional administration and the inmates. The underground inmate society has norms, patterns of behavior, and goals different from and usually in conflict with those of the overall institution. This is partly due to the fact that inmates cannot rise in the status system and become staff.

The inmates and officialdom are divided into two segregated strata. The inamtesmay, in one context, be viewed as a caste of untouchables. They are restricted to an inferior position in the hierarchy, and in prison there is no possibility of their moving up. It is conceded by most correctional administrators that this inmate-administration conflict situation contradicts and impedes therapeutic progress for the inmate.

The inmate subsystem helps the patient or inmate cope with the new set of problems that he finds in most institution. He feels rejected by the larger society and tries to compensate for this rejection. One way he does this is to reject and rebel against the administrators of society's rejection--the custodial staff.

A true TC does not have a "we-they" caste system. It provides an open-ended stratification situation. Upward mobility is distinctly possible in the organization, and in fact, upward movement in the system is encouraged. As on TC leader told a newcomer during an indoctrination session, "In a couple of years...you just might be a big shot around here and have my job." Not only is upward social mobility possible in a TC, but healthy status-seeking is encouraged. This type of upward mobility is not possible in a traditional institution.

A TC organization assumes, with some supportive evidence, that a person's position in its hierarchy is a correlate of social maturity, "mental health," increased work ability, and a clear understanding of the organization. Another assumption is that the social skills learned in a TC structure are useful within the larger society. The reverse appears to be true of the "skills" learned in custodial institutions. The "we-they" problem does not exist in a true TC structure since the administration and the "inmates" are one and the same, and upward mobility is encouraged in this open-end stratification system.

Personality Change in a TC: Eliminating the "Criminal Mask"

Most drug addicts and criminals who enter a TC have a tough facade or a "criminal mask" that they developed in their deviant lifestyle to survive on the streets. A postulate in a TC is that this face to the world must be changed and a new one developed. This involves a 180-degree turn from the offender's past patterns of behavior. In a TC, criminal language, jargon and values are viewed with disdain and extreme disapproval. The newcomer may hang on to his past destructive mold for a brief time. In short order, however, new words and behavior patterns are ruthlessly demanded in an effective TC.

Charles E. Dederich, the founder of Synanon's TC work, made the following cogent remarks on this issue. Dederich described part of Synanon's resocialization process as follows:

> "First you remove the chemical. You stop him from using drugs and you do this by telling him to do it. He doesn't know he can do it himself, so you tell him to do it. We tell him he can stay and he can have a little job. We tell him we have a lot of fun and might get his name in the newspapers. We say, 'People come down and you can show off and have a fine time as long as you don't shoot dope. You want to shoot dope, fine, but someplace else, not here.' Then you start working on secondary aspects of the syndrome. Addicts live by the discipline of narcotics; therefore, they talk about this all the time. They discuss petty theft and short con; none of them is well enough for a big con. Addicts never pull any big scores; they can't--they're sick people. They talk about this.
>
> "The next thing you do is attack the language. Eliminating their criminal language is very important. We get them off drugs by telling them, 'Live here without using drugs and you can have all this.' We get them off the negative language by initially giving them another. Since there is some vague connection between their personality problem and the social sciences, we encourage them to use this language. The language of psychology and sociology is great stuff. Whether or not the recovering addict knows what he's talking about is exquisitely unimportant at this time.
>
> "Very quickly, in a matter of about ninety days, they turn into junior psychiatrists and sociologists. They become familiar with the use of a dozen or twenty words and misuse them. Who cares! It doesn't make any difference. Now they're talking about 'the unconscious,' 'transferences,' 'displacement,' 'primary and secondary groups.' This is all coming out, and they're not saying drugs, 'fix, fix, fix' all the time. 'I used $100 a day.' 'Joe went to jail behind this broad.' 'Where did you do time?' and all that. They get off that, and they talk about ids, superegos, and group structure.
>
> "They make another set of noises, and their criminal facades drop away."

Language is, of course, the vehicle of culture and behavior; and in a TC, it is instrumental in shifting the behavior patterns that the addict has used in the past. He begins to use a new, still undeveloped set of social-emotional muscles.

TC members are not identified as wards, prisoners, or patients, and this also makes a big difference in their self-identity and outlook. The person can identify himself with the constructive goals of the organization for which he works. He automatically becomes an employee in the TC organization, at first on a menial level. Later on, he is encouraged to take part in the TCs management and development.

In the traditional institution, the inmate feels helpless and hopeless about his destiny. He has limited power in the institution, since it is run by administrators who are indifferent to his opinions about its management. Moreover, as we have noted, prison administrators are seen as representatives of society's rejection of the inmate, and this sets up additional blockades to his progression in the custodial institution. Inmates have a clear authority object for their frustrations and hatreds--the custodial staff. In a TC, there is no such split, since the administration consists of co-workers and colleagues. There is no "they" to hate within the organization.

Involvement in a TC helps to foster empathy in a person whose basic problem is alienation from society. Identification with the TC involves feelings of concern for the other members and for the destiny of the totality of the organization. The development of these empathic qualities reverses the person's past sociopathic lack of social concern and has a real impact on positive personality change. Vital to this personality change are various group processes.

Group Psychotherapy in Correctional Institutions and in a TC

All TCs have some form of regular group process built into their social structure. One significant major difference between TC group therapy and the usual institutional forms of group psychotherapy is that the TC sessions are not usually directed by professional therapists. There is considerable evidence that inmates participate in group psychotherapy with an eye on the gate leading out of their prison or hospital. Consciously and unconsciously, the inmate may verbalize "insights," seemingly indicating therapeutic progress, in an effort to convince the therapist and custodial officials that he has changed and is ready for release. At a group therapy session I observed in a California prison, several inmates made a great show of getting wonderful insights, and as one fellow put it, "This program really makes me see life more clearly." But several inmates admitted in private, "Of course, I want to look good to get out of this joint."

TC sessions are more closely related to the real life and work problems that confront the members. Given the lack of caste division, lines of communication are open throughout the organization. This, plus a goldfish bowl atmosphere, is conducive to a more extensive examination of underlying problems. TC group sessions make intense efforts to surface all possible data about member since this is vital to the protection and growth of both the person and the TC organization. Since all TC members work for the organization, many real on-the-job problems are funneled into the TCs group psycho- therapy. All of these factors give a TCs group process a reality not found in the closed-off social systems of custodial institutions.

In summary, the following elements reflect the significant difference between the social structure and organization of effective TCs and traditional correctional institutions:

- There is a qualitative difference between indoctrination in TCs and in other settings. The contractual arrangements for therapy and the prospect's expectation of success are different. The indoctrination of the prospect by people who have themselves been in his shoes and succeeded appears to be a significant element, providing the newcomer with a role model of what he can become. Also, the "indoctrinator" sees where he was when he looks at the newcomer, and this is valuable for reinforcing his personal growth.

- TCs provide the possibility of upward mobility, whereas most institutions are caste systems. Becoming a TC member provides incentive for changing one's criminal motivation to anticriminal motivation. The TC resident can actually achieve any role in the organization. In contrast, in the custodial institution, an inmate or patient is locked into the inmate position.

- There is a qualitative difference between the TC and the form of group therapy carried on in prisons and hospitals. This is partly a function of the described differences in the overall social system context. The TC resident, as a voluntary participant, has little to gain from faking progress, whereas in other institutions, the appearance of being "rehabilitated" may be rewarded by an earlier release from custody. The TC person is encouraged to reveal and deal with his problems honestly by others who have traveled the established TC route to recovery.

- The TC subculture is integrated into the larger societal structure in a way that traditional institutions never are. The flow of members of the community through a TC and the participation of TC members in the larger society place it closer to the reallife situations of the outer world than the artificial communities of the traditional institutions that attempt personality change.

- The work assigned in a TC is real work, unlike the often contrived jobs in prisons and mental hospitals. All work serves the real needs of the organization. This includes the functions of the procuring of food, an office staff, maintenance and service crews, automotive crews and the coordinating staff. Everyone in a TC should have meaningful work to do.

There has been attempts at self-government in prisons and hospitals. In these settings, however, the inmates recognize that final decisions on important policy matters remain with the administration. In a TC, perhaps for the first time in his life, the member assumes a significant role in controlling his future. Leadership in a constructive situation is a new experience for him, and it appears to develop personal responsibility. The residents of a TC, unlike patients and inmates, are involved with the growth and development of their own organization. Because there is a generally held belief by the residents that "the TC saved our lives," the esprit de corps in the organization is quite powerful. Few inmates would give three cheers for a hospital or a prison, but in a TC, people seem to enjoy praising the organization that saved their life. They work hard for its growth and development.

THERAPEUTICS & INCARCERATION: THEY SAID IT COULDN'T BE DONE

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Stay'n Out Criminal Justice Program is a modified TC operating within prison walls for the New York State Department of Correctional Services: Arthur Kill in Staten Island for males and Bayview in Manhattan for females.

Among its accomplishments are: first program to establish a TC in a Corrections facility for men and women; first program of its kind to be completely funded by New York State Department of Correctional Services; first program of its kind to endure within the New York State Department of Correctional Services for 2 years; first program which is not a part of New York State Department of Correctional Services to be allowed to hire graduated program participants (ex-inmates) to work in the same facility in which they were previously incarcerated; first program granted permission to employ parolees (ex-inmate program participants as staff in Correctional facilities) and; first program to show a recidivism rate of less than 10%.

As early as the 1970's and even around the world today in certain areas, the word is that "therapeutics" and "prison" can't mix. It is said that "it will not work." For eight years now the Stay'n Out Criminal Justice Program has been blending therapeutics and incarceration with success.

In the year of its inception, 1977, there were 17,000 plus inmates incarcerated in New York state, about 700 of whom were females, and about 65% of all were incarcerated for substance abuse and/or drug related crimes. This year, 1985, eight years later, there are 35,000 plus inmates in New York state. The female population has increased to approximately 1200 and the percentage of individuals incarcerated for substance abuse and/or drug related crimes has also increased to approximately 68%.

Stay'n Out Criminal Justice Program offers the incarcerated men and women an opportunity to spend their time in treatment and re-entry settings designed to relieve their disabilities.

Stay'n Out delivers quality treatment to its population, reducing slowly the growth of the prison system by salvaging motivated individuals, thereby lowering the recidivism rate and producing productive citizens returning to local neighborhoods.

The Stay'n Out Criminal Justice Program's existence for eight years has thoroughly proven the viability and effectiveness of its model.

THE TC'S ROLE IN THE PRIVATIZATION OF CORRECTIONS

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The privatization of corrections may hold a key to meaningful prison reform which has been eluding policy makers for a long time. The issue is overcrowding; if we keep "locking them up" without considering alternatives and how to decrease recidivism rates the cost of warehousing prisoners will continue to skyrocket and become intolerable. Recently, many government officials at the local, state and federal level have turned to the private sector to find the resources and technology to solve correctional problems.

Therapeutic Communities have had notable success in treating criminal justice clients within the community and have shown promise as an effective modality for prison-based treatment. There is a unique role for the TC in private prisons that needs to be recognized and integrated if privatization is to facilitate meaningful rehabilitation that can reduce recidivism rates.

An overview of recent privatization developments and recent issues indicate the effectiveness of the therapeutic community approach for prison inmates. The therapeutic community can play a productive role in the privatization of corrections.

PRIVATE THERAPY AND PUBLIC CONTROL IN GERMANY

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Since 1982 the German Controlled Substances Act (Betaubungsmittelgesetz, cited BtMG) has recognized privately run drug treatment programs as an alternative to imprisonment, thus making drug treatment a part of the system of criminal sanctions. The legal basis for this treatment is a private contract in which the drug user must give his consent to the therapy. The law, however, gives preference to prison-like treatment programs and, indeed, many therapies entail severe restrictions on the client's constitutional rights, such as restrictions on freedom of speech, freedom of movement and the right to privacy. Because these restrictions make therapy almost indistinguishable from punishment, there is no real choice between therapy or punishment at all, and hence the contract fails to meet the "freedom of choice" standards necessary for a valid contract under German constitutional law. I believe that a statutory solution to these problems, which would spell our the rights of the client while undergoing therapy, can only provide temporary alleviation. In the long run decriminalization of drug offenses would seem to be a more effective guarantee of the drug offender's rights.

Therapy in the place of punishment has been advocated in the USA for a long time now. This discussion has lead, especially here in California, to many varied forms of social-therapeutical services in public, semi-public and private programs. In Germany, the search for alternatives to the normal methods of punishment is also being intensified. Such alternatives are most easily introduced, as well as being most sorely needed, in those areas in which the traditional criteria for medical or psychiatric treatment are evidenced, i.e. precisely in those areas in which the advantages of criminal punishment are minimal. Treatment of drug users is increasingly being recognized as just such an area.

Historical Background

Up until the present there were about a dozen ways of bringing drug users into custody in order to begin therapeutic treatment. One is very similar to the Lauterman-Petris-Short Act of the California Health services Code, which permits taking drug users into custody if they present a danger to themselves or others. Other possibilities include a declaration of mental incapacity or, with juveniles, a delinquency proceeding. Such proceedings must be brought before the guardianship courts. In criminal proceedings the courts could always suggest therapy for drug-related crimes in cases where probation was appropriate. This followed in accordance with the German Penal Code (Strafgesetzbuch) and encompassed treatment in a psychiatric hospital, an institution for drug and alcohol treatment, or a therapeutic institution.

The provisions of the newly revised Controlled Substances Act, which expressly adopts the principle of "therapy instead of punishment" for drug users, changes all this. This new law permits the court to disregard a prosecutorial complaint or to suspend the criminal proceedings temporarily if the accused can prove that he has been undergoing treatment to help rehabilitate him, for a least the last three months, because of his addition. The court can also set aside the sentence or suspend the remainder of the sentence with probation, taking into account the time spent in treatment. The precondition for the state's nonprosecution requires that the accused be unertaking therapy because of his addiction and that this therapy aides his rehabilitation. The term "therapy" includes only a stay in a state-recognized institution that serves to end the addiction or to counteract a renewed addiction. An Amendment to the Controlled Substances Act now permits treatment in private facilities as an alternative to the public ones.

Structure of Therapy: The Therapeutic Community as Prototype for German Facilities

Anyone scrutinizing the therapy scene in Germany cannot help but notice the structural similarities of most facilities. They orient themselves to the prototype of a "therapeutic community" but still exist essentially as professionalized facilities. "Therapeutic communities" make up the lion's share of the treatment facilities offered in Germany insofar as the need is not covered by private or public hospitals. The methods applied vary essentially between psychotherapy, social-therapy, work therapy and social-pedagogical approaches whereby different approaches are frequently applied next to or mixed with one another.

Normally a certain lifestyle and form of social behavior go hand in hand with the therapy. Frequently the clients of the TC are exposed to a hierarchical relationship with strict rules of conduct and a differentiated system of reward and punishment. In addition to working out those difficulties connected with their drug consumption, the individuals should as a rule also learn, anew or once again, to çorganize their everyday lives (work/apartment/free time/etc.). The different forms of activities offered (individual or group settings, work duties, etc.) have to be seen in this light. After all, we are dealing here with a concept that aims at a fundamental change in behavior through a continual round-the-clock process. For this reason these normative-oriented facilities are also characterized as "secondary agents of socialization" and with a view towards their structure as "collective therapists."

The Legal Relationship between Client and Therapeutic Facility

Precondition to admission to treatment is customarily an application by the drug addict to the therapeutic facility in which the program is to be completed. In addition, the client must sign a declaration of voluntariness and at the same time subscribe to the written and unwritten rules of the facility. Because of the duty to register the clients place upon these facilities, the client must also release his therapist from his privilege against disclosure.

A cursory look might suggest that even with the indirect participation of state agencies, the client and the therapeutic facility come into contact as private individuals. The client reaches a contractual agreement with the facility that covers room and board, also frequently medical services, as well as the "presence of the proper social-therapeutic milieu," i.e. the therapeutic programs necessary for successful treatment. The facility in no way obtains any sovereign authority through this contract. It cannot, for example, take any measures against the client's will that entail restrictions on his freedoms. Therapeutic facilities are thus left with only one possible sanction for continual violations of house rules: the revocation of the private contract for treatment or the threat thereof. Hundreds of convicted drug users subject themselves time and time again to grevious invasions of their right to privacy through the rules that result from these private contractual agreements. One asks, "Why?"

Drug Therapy: Serving Time in Private Institutions?

There are several points that give cause to question the private character of this form of treatment. They are to be found in those paces in the Controlled Subetances Act in which the therapeutic facility is the direct recipient of statutory duties through this legislation. For example, a judicial order requiring therapeutic treatment is directed at the convicted drug user whereas BtMG required that "the person applying treatment or the facility inform the authorities of a break in the treatment process." The statute thus contains a legal duty, which the treating person has to obey, even though he is in most cases neither a participant in the criminal proceedings nor a member of the legal apparatus. The information concerning a break in the treatment leads to the reintroduction of the criminal proceedings or the carrying out of the remaining sentence. At least ion the last case, the treating facility is directly active in the sentencing procedure. The violation of this duty to inform can lead to the loss of state accreditation, which leads us to the second drawback of this statute.

State accreditation is based on two preconditions: 1) the duty to register clients must be met and 2) a therapy concept recognized by experts must be presented. State accreditation is optional. The loss of it brings, however, the risk of considerable financial loss because the therapeutic facility must reckon with not being considered anymore when it comes to transferring clients out of the criminal system and into therapy. The evaluation of the treatment's success offers a further example. According to BtMG, the criminal proceedings are to be reinstituted if the therapy is not to be continued to its foreseen conclusion. The concept of the conclusion of treatment, is, however, basically to be defined by the treating facility. In this manner, the facility also obtains decisive competence in deciding upon the reintroduction of the criminal proceedings or the reinstitution of the remaining sentence.

The criminal character of these provisions is even more accentuated by the structure of the drug therapy favored in the statute, which is similar to penal conditions. According to BtMG, the time spent in the treatment facility will only be deducted from the remaining sentence if the convict was treated in a state-accredited facility in which the structuring of his lifestyle was subject to considerable restrictions. If the drug user decides to use a less restrictive form of treatment, e.g. outpatient therapy, then he must realize that is case of a relapse, breaking treatment or recidivism, he might have to serve the whole original sentence. In the eyes of the statute, the treating facility takes the place of the penal authorities and maintains in essence its structure. Those concerned also perceive it this way. Even if one wanted to negate a direct connection with the execution of the sentence, as evidenced by the cessation of the criminal proceedings or the suspension of the sentence, one cannot overlook the fact that private therapy facilities are drawn upon by the state to fulfill their public function of reintegrating criminal drug users into society. For this reason, they are also to be seen as part of the criminal justice system.

The Fashioning of Therapy in the Light of Constitutional Law

If drug treatment facilities are to be included in the state system of sanctions, one has to consider whether the same legal principles should apply to them, when they encroach upon the rights of third parties, as apply against state institutions. The measures to which drug users are subject in treatment facilities touch many varying fundamental rights. I would like to mention just a few of these in the following part of my paper.

First, clients of therapeutic facilities as a rule cannot dispose of their property as they want. Sometimes this commonly accepted right is totally revoked, although it is usually only greatly restricted. A stay in a therapeutic facility is frequently connected with exhaustive work duties (kitchen, garden, renovations, etc.). Mail is often censored or retained for short periods of time. Letter-writing is partially forbidden. The use of television and radio as well as the opportunity to read magazines are from time to time restricted or not at all provided. Freedom of movement is at first restricted to the treatment facility itself and is only enlarged step by step. Even after finishing a considerable part of the therapy, a client can be punished for a violation of the rules. Even the right of self-determination is touched by these intrusions, e.g. regulations concerning appearance (haircut, clothes, lifestyle), required participation on therapeutical and other activities, as well as aprohibition of sexual and other contacts.

In so far as therapeutic facilities build a functional substitute for state action, they are subject to the same constitutional provisions. Basically, no private person may exercise sovereign authority over another person; that includes undertaking measures that restrict fundamental rights. Such an invasion of these rights would not be present if the clients had consented to treatment programs and the restrictions on their rights which come with these programs. For this reason, just about every convict who goes into therapy signs a so-called statement of voluntariness before admission in which he declares himself ready to accept the facility's programs. At least this is the way participants have interpreted this policy.

Such a procedure presupposes the client's ability to waive his fundamental rights voluntarily. This is certainly possible for the average person. The ability to consent is also present for drug users, for they possess the abilities necessary to understand and judge their waiver. Still, in addition to these abilities, the law requires the actual freedom to give consent, if the waiver is to be effective. In accordance with constitutional law, a waiver of a fundamental right can only follow when this freedom is evidenced by alternatives from which the individual could freely choose.

In accordance with this principle, the Constitutional Court of the Federal Republic of Germany found in a murder case, where the accused wanted to prove his innocence by taking a lie detector test, that the accused had no real freedom of choice. The lie detector test presented an offer that he could not refuse as it presented the only possibility of not being convicted. This principle of constitutional law has ramifications for the problem with which we are dealing. In a proceeding in accordance with BtMG, the accused's statement of voluntariness can hardly serve at the same time as an effective waiver of his constitutional rights because of the constant threat of incarceration. The same is true of the duty to register, which coerces the therapists to waive their therapist-client priviledge. These regulations in the Controlled Substances Act take away a great deal of the accused's protection in the area of doctor-patient (or here, therapist-patient) relationships.

As no effective waiver is present, the question remains to what extent the statutory provisions of this act allow invasions of the fundamental rights of those concerned. In German law, the transfer of public functions to private institutions follows through a state act ("Beleihung"). This leads to the creation of legal relationship of a public character between the empowered agency (e.g. TCs) and third parties, insofar as the relationship is based on the state act itself. The private agency then becomes an organizational part of the public administration. The necessary protection of individual rights from sovereign acts of the agency thus becomes a part of the normal judicial control of administrative agencies.

In accordance with Article 20 of the Basic Law of the Federal Republic of Germany (Grundgesetz), any state action that affects individual rights must be based on a written statute. Case law has interpreted this preference for written law to cover all those areas that are essential to the realization of the individual's fundamental rights. In the present case, this would require a more careful structuring of those procedures that are used within the framework of the therapy relationship and have a direct significance for the realization of fundamental rights.

The provisions of the Controlled Substances Act provide for the undertaking of therapeutic services by private facilities, but are so unspecific that they fail to provide the actual structure that the therapy should take. Besides the expressly mentioned transferral of legal competence, there is no specific mention of or limitation on the authority of the facility, and this in spite of the many possible violations of fundamental rights which I have previously stated. All regulation is left up to the therapeutic facility. The Controlled Substances Act thus fails to meet the constitutional requirement that it cover all of the determinative factors within the normative area that it regulates. For this reason, this act does not present a legally effective assignment of state functions that would provide the therapeutic facilities with a basis for their invasion of the fundamental rights of those concerned without their valid consent.

In summary, one can see that drug therapy is being taken out of the private sector and placed in the public sector. It is a fiction to believe that this previously mentioned "agreement of voluntariness" is actually based on the individual's freedom to contract and is supported by his equality before the eyes of the law. In reality, the convict sells his individual freedom as the price of a successful reintegration under the threat of punishment. This represents an invasion by the state of his fundamental rights, which are protected by the constitution.

If the legislators force drug users into a therapy that is the functional equivalent of incarceration, then it must also meet constitutional standards. Invasions of the accused's fundamental rights within the framework of this therapy are thus inadmissible as violations of the previously mentioned preference for statutory regulation, insofar as therapy is given in connection with the Controlled Substances Act.

Alternatives

What can we do? Do we need a new law covering the serving out of drug therapy? At first glance a traditional jurist might say yes, and at the same time, think of other areas that concern the execution of sentences. Still, two arguments speak against such a statutory solution. First, as my critique is actually directed against the deficiencies of statutory control, one can hardly expect a new statute to solve these problems. In any event, it would most likely only result in maintaining the status quo. The violations of fundamental rights would simply be written into law. My second point is more fundamental and involves the thesis that the problems that arise in drug therapy can only be solved to a minor extent through legal regulation. This thesis is closely connected with the discussion concerning the steadily increasing legal regulation of previously non-regulated sectors of life. The German philosopher, Habermas, has characterized this phenomenon as the colonialization of life's spectrums ("Kolonialisierung der Lebenswelten").

If one imagines this invasion of legal regulation in the are of therapy, it becomes quite clear that various fundamental contradictions exist. Therapy, especially life in a TC, is necessarily dependent on mutual recognition, understanding and respect. The fundamental presupposition of any successful treatment -- trust -- cannot be coerced through legal regulations. In such cases, the appearance of the client in court would signify the end of any possibility for successful treatment. If the advisor or therapist is required to behave by the book, the negative effects would be deindividualization and formalization; in short, bureaucracy instead of communication. This can be seen already in the latest developments in the area of legal control of the medical field.

If the law is unsuitable as a means of providing clients with the proper therapeutic atmosphere necessary to bring about a speedy recovery, i.e. through a discursive process involving coercion, manipulation and conditioning, one asks what might provide a solution. The answer is deregulation, a concept that has been used up until now in other administrative areas. Deregulation could serve to solve the constitutional problems that I have previously mentioned. The main problem with the Controlled Substances Act was the lack of voluntariness on the part of the client which resulted from the threat of punishment and the prohibition on drugs and drug use.

In its Report of Decriminalization, the European Committee on Crime Problems developed several suggestions towards society's dealing with drug problems in a more rational way without using criminal law. I do not want to go into these suggestions in detail, as the concepts of decriminalization and legalization are also well known and heavily discussed here in the U.S.A. The results of deregulation of drug crimes would bring about two positive effects: overcoming the illegality problem and all of its consequences and reintroducing voluntariness in therapy.

Conclusions

1) Voluntariness in therapy would mean that punishment no longer provided the inducement to therapy. Drug users would then be treated just as alcohol-coffee-tobacco consumers, neither privileged (therapy instead of punishment) nor discriminated against (punishment only for çthe use of certain drugs).

2) Outside control through state or financial institutions could be done away with, at least as far as the clients are concerned.

3) Treatment could be restricted to the addiction.

4) Self-help could take on new meaning and provide greater flexibility (therapy without punishment). Self-help groups could be used in non-drug-free areas.

5) Legal regulations appear to me to be less than helpful in securing the rights of drug users to therapy. At best they provide a crutch at present during a transitional period, in an attempt to bridge the present unsatisfactory conditions. Decriminalization in the sense of deregulation is in the long run the best alternative to protect the rights of drug users to therapy.

TWO ALTERNATIVES FOR DRUG ADDICTS PRISON OR TC

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For a few years now there had been a lot of debate in Italy over the idea of changing the criminal code to offer drug addicts in prison an alternative to their sentence. One alternative considered is the TC.

This debate is very animated for two reasons: on the one hand the particular situation of drug addicts in Italian prisons and on the other hand, the remarkable recent development of TCs in Italy.

As far as Italian prisons are concerned, out of 45,000 inmates, at least a third are serving sentences for crimes connected with the use of narcotics. These crimes go from dealing narcotics on a small scale to theft and armed robbery committed to finance a drug habit. This high number of inmates who are drug addicts causes continuous tension in the prisons. The overlapping of the drug sub-culture and the prison sub-culture creates an explosive mixture which makes it difficult to maintain discipline.

Alternatives to imprisonment would, therefore, decrease the prison population and, at the same time, provide programs for the rehabilitation of drug addicts, programs which are now nonexistent and are impossible to set up inside the prisons.

Now, turning to the therapeutic communities, their remarkable development in recent years and the interest aroused by the sensational trial of Vincenzo Muccioli, founder of the Comunita di San Patrignano, have made many people think that these communities work miracles and that the TC is a solution to the problem of the rehabilitation of drug addicts which can be applied to every case of this kind. If you add to this the fact that at San Patrignano there are numerous drug addicts who have had problems with the law and who have been granted house arrest in that community, you can easily see why there is so much interest in proposals for the rehabilitation of drug addicts outside the prison system.

The problems of drug addicts in prison are also likely to get worse in the future. It is a well-known fact that most drug addicts have problems with the law, that is they commit crimes to obtain narcotics. The least of these crimes is that of dealing narcotics in small quantities. The image of the consumer/small-time dealer is so familiar that it is not exaggerated to say that almost all drug addicts could be charged with the crime of dealing small amounts of narcotics. This crime is punishable with a sentence of 2-6 years imprisonment and, particularly in the case of a second or third offense, the drug addict will end up in prison.

There is also a growing tendency for defendents in trial to collaborate with the law. They name their accomplices and others in exchange for greater leniency on the part of the judge. This custom, which until recently was used mostly in the big trials involving terrorism and the mafia, is now becoming common in trials involving drugs. If this tendency continues, the number of drug addicts who are either charged or convicted and imprisoned will increase in geometric proportions.

This situation reveals a contradiction between the various programs set up for the control, repression, or rehabilitation of drug addicts. On the one hand, the laws regarding the consumer/small-time dealer lead to more and more frequent trials and convictions which increase the total number of drug addicts in prison. On the other hand, because of the heated debate in cultural and political circles caused by the increase in drug addiction, the government is more actively supporting projects for the rehabilitation of drug addicts, specifically the TCs. And here lies the contradiction: consumers/small-time dealers are sent to prison where they cannot do a rehabilitation program, but funds and other resources are set aside to support forms of therapeutic treatment which are designed to help these same individuals break their habit.

The proposal to offer the imprisoned drug addict an alternative to his prison term which would be admission to a TC seemed to many a solution to two important problems. It would rehabilitate thousands of young people who are victims of drug addiction. It would also make the prisons more "governable" by removing the drug addicts who are easily blackmailed and used by organized crime and are an element of continuous tension, corruption and disorder.

Recent bills that are beginning to be discussed by the Italian Parliament have moved in this direction. They propose various legal alternatives for drug addicts who committed crimes because of their drug addiction and who would voluntarily enter a therapeutic program. These alternatives include suspension of warrants for arrest or of the trial, the conditional suspension of the sentence, and the concession of parole. If the therapeutic treatment is successful, there are various proposals for even more lenient treatment, some of which go as far as to propose that the crime be struck from the record.

Confronted with such enticing solutions that seem to resolve everything, done, with people who work in or have great experience with TCs, like Don Mario Picchi of the Centro Italiano di Solidarieta, Claude Olivenstein of the Marmottan Hospital of Paris, officials of the French Ministry of Justice, and representatives of therapeutic programs in France, have expressed almost unanimous disapproval. The opinions expressed by the French authorities is of particular interest because since 1970 in France there has been a law which offers the drug addict an alternative between a trial and therapeutic treatment.

The reasons for these negative reactions to the establishment of therapeutic treatment as the alternative to a prison term seems very simply and convincing:

- First, the fact that a drug addict voluntarily chooses to enter a TC is an essential element for his success in that program. The choice between prison and TC is not a choice; it is settling for the lesser of two evils.

- Secondly, the TC is a method of rehabilitation which works for not more than 10-15% of all drug addicts. This percentage would remain the same if applied to convicts.

- Thirdly, treatment in a community has one primary objective which is to recuperate the personal identity of the drug addict. This identity is rebuilt through discipline and a series of precise, clear rules of life. But if a drug addict were doing a therapeutic program as an alternative to a prison term, this discipline and these rules would be seen as punishment for a crime and not as tools for living.

- Fourthly, overlapping the drug sub-culture and the prison subculture would have a disastrous effect on the running of the TC. It would create a conflict between the therapist and the parole officers who have two functions and two ways of working which are completely different and irreconcilable. TCs set up inside prisons in Switzerland, Holland, and Belgium have failed because of this problem which created enormous tensions and conflicts in both the therapist and the addicts themselves. In France, the young person leaving the hearing where his sentence to a prison term had been communted so that he could enter a TC would be heard to say, "I have been sentenced to therapeutic treatment". This demonstrates the total confusion which this alternative creates between therapeutic objectives and punishment and repression.

- Finally, even if the alternative prison/TC, in spite of all these arguments against it, were to be approved by the legislature, it would still be very difficult to put into effect. It would take years and years of work to create a chain of TCs large enough to accommodate thousands of drug addicts, if only because the preparation of staff takes such a long time. Therefore, there would be the risk of creating an expensive bureaucracy which is very rigid and guarantees only its own permanence. It would be unable to fulfill the tasks it was created for, but also unable to declare itself a failure.

There is much more need for experimentation in this area than for expensive bureaucratic structures. And there already is in Italy an example of a community which takes in convict/drug addicts without raising any particular objections or problems. I am speaking of the Comunita di San Patrignano which has more than a hundred residents. We should therefore move very carefully and openly, attempting to honestly evaluate this and another experiments before creating a large bureaucracy which repeats them.

The French experience is particularly important. A law of December 31, 1970 established the possibility of a "therapeutic injunction" to be applied in cases where the drug addict had committed small crimes connected with supporting his habit. In these cases the prison sentence was waived in favor of admission to a TC.

Well, fourteen years later, the failure of this law, already noted by those who work closely with it, had now been officially recognized by the Ministry of Justice. In a circular letter of September 1984, 1984 they admit that "only modest results can be expected from therapy based on constraint which overlaps the roles of doctor and judge in ways which the drug addict finds difficult to understand". And in another part of the circular the district attorneys' offices are asked to see if, in concrete cases, the addicts role as a drug dealer doesn't take precedence over his role as a consumer. In this case he should be prosecuted by the law without using the therapeutic injunction of 1970 which obliges him to enter a TC. The same applies to cases of crimes against people or property where the defendent claims to have acted under the influence of drugs or to obtain drugs. Here the ministry also advocates that judges not apply the 1970 law which gives the defendent an alternative between a trial and other treatment.

The position taken by French social workers and community staff is even more drastic. For a long time now, they have pointed out the ambiguity of the 1970 law which confuses the role of therapy and the role of the judicial system. They have also noted the risk that excessive permissiveness will now be subsituted by particularly severe treatment for crimes committed by drug addicts.

Their advice is to consider the convict/addict as the same as any other convict. He can be offered the possibility to begin a therapeutic program while in prison if he asks for it. But this would be completely independent from his other problems and from his status with the law.

These evaluations are even more important when you consider that they come from officials of the Association "Trait d'union" of Paris. This group was founded in the mid-70's specifically to take responsibility for convict/ addict and to get them started in an appropriate therapeutic program. In other words, those who promoted the 1970 law now recognized its failure and warn against any attempts to overlap a therapeutic structure and the prison structure, or to set up therapeutic departments in prisons. This fact should be taken into account seeing as in Italy we seem about to try this same thing.

PROPOSED SOLUTION IN ITALY

Actually, after the first rather excessive enthusiasm for alternatives to a prison term, there is now a tendency toward careful experimentation in Italy. This can be seen in the recent law of June 21, 1985 (number 297).

The provisions of this law are significant and offer an attempt to resolve an international problem in every country where drug abuse has become a mass phenomenon, there is a closer and closer relationship between drug addicts and the criminal justice system.

The Italian law of June 1985 is divided in two parts that don't seem to have any connection at all. The first part provides that funds be distributed by the Ministry of the Interior to public agencies and also to non-profit organizations of volunteers, cooperative or private, that carry out programs for the rehabilitation of drug addicts. This is the first time that the Italian government has made a direct financial commitment to support various forms of treatment which are run privately. Even though the state has allocated very few funds up to this time, this law seems to recognize the significant role of the various private therapeutic programs, religious and non, in the difficult takes of rehabilitating drug addicts.

The second part of the law provides for a first cautious alternative to a prison term for those drug addicts who are accused or convicted but are already undergoing therapeutic treatment in an agency, public or private, which is eligible for financial aid from the State.

And here the connection between the two parts of the law becomes evident. The State is trying to set aside funds for programs for the rehabilitation of drug addicts and, at the same time, deal with the contradiction that we have pointed out from the beginning. This contradiction is that the drug addict receives repressive treatment in prison which excludes the possibility of his rehabilitation, and yet funds are set aside for the therapeutic treatment of the same drug addict.

This law offers alternative systems to that of the prison which seem adequate to overcome the otherwise enormous contradiction between the repression in prison and the rehabilitation of drug addicts. The law uses the system of probation which is already part of the penal code, modifying it to suit the particular situations of drug addicts. if an addict who is already following a therapeutic program is sentenced to a prison term of not longer than two and half years, he can ask to be paroled to continue his therapeutic program. If the period of parole ends without incident in a period of time equal to that of the prison sentence, then the sentence is canceled and crossed off the records.

The primary objective of the new law is to avoid the negative consequences of a prison term on those drug addicts who are already following a therapeutic program. It is absurd that drug addicts who are doing a therapeutic program and who are therefore already outside the vicious circle of drug addiction are then imprisoned for crimes committed before beginning treatment. This nullifies the rehabilitation work that the addict has done and usually means he will return to narcotics.

The alternative to a prison term is offered by this law only to those drug addicts who have already freely and spontaneoulsy chosen to enter a TC, without the added push of wanting to avoid going to prison. This is to prevent a generalized appeal for this alternative which could be used as a way to escape a prison term and nothing more.

The other provisions of the law work for the same ends. For example, a judge who is trying a drug addict who is already doing a therapeutic program must consider the risk that stopping that program would be to his rehabilitation before passing his sentence. When a drug addict who is doing a therapeutic program in prison is let out on bail, the judge must also take into consideration that the therapeutic program can work much better if the drug addict is outside the prison.

And so it seems that the law has found an equilibrium between the need to provide ways of rehabilitation for drug addicts who are on trial or already convicted and the danger of offering a generalized alternative to a prison term which contrasts with the fact that a drug addict must do a therapeutic program spontaneously and of his own free will.

We cannot now foresee how many drug addicts who are on trial or convicted will be able to use the parole system to continue a therapeutic program without having to go to prison. The frequent stories of young people who have left the world of drugs and then are arrested or convicted while they are doing a therapeutic program lead us to assume that this new law could affect a few thousand drug addicts.

If this law works, it will be a big step forward in overcoming the contradiction between repressive penal action and rehabilitation. Until now, this has given the unfortunate impression that a drug addict who is on trial or a convict is excluded from any type of rehabilitation, even if he has already left the world of drugs and in so doing has resolved the problem which caused him to commit crimes.

We would also like to point out one gap in the law. The alternative to a prison term is available only to drug addicts who are following a therapeutic program and not to ex-drug addicts who have already finished a rehabilitation program and are living normal lives.

It will not, however, be difficult to fill this gap by making it possible for an ex-drug addict to have the sentence annulled or communted to an equal period of social service with health organizations, schools, or other volunteer community services.

In the case where the ex-drug addict who has to serve a prison sentence is a person who could be a staff member in a TC for drug addicts, his social service could be done in one of these communities. But, in this case, two conditions must be respected: first, the ex-drug addict must voluntarily decide to work in the TC and, second, the community must also voluntarily decide that he is right to work there.

With these additions, the law would recognize the already established chain of solidarity in which many ex-drug addicts dedicate themselves to help to rehabilitate other young people, victims of the slavery of drug addiction. And we would see the criminal justice system enter rehabilitation programs without contradictions.

DRUG ABUSE IN COLOMBIA

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For a long time, there has existed a false preconception regarding Colombia. It was seen as merely a country which served as a bridge for the trafficking of drugs, but it was ignored that a dangerous and phenomenal usage of drugs exists in Colmbia itself. It is a practice among certain indigenous peoples to use cocaine for its properties as a stimulant. Coca leaves were chewed to calm hunger, during physical labor, to cure illness and was an indispensable ingredient in religious celebrations. Without doubt, cocaine was destined for personal use, even before its commercial use was exploited.

Not only have the existing socio-economic problems facilitated the displacement of a vast amount of people into the marketing of drugs hoping to gain rapid and easy riches, but also the number of nationals using drugs multiplies each day. Due to this national preoccupation, we have had to admit that a large sector of our community is destined to become consumers of drugs. The principal method of use at this time is *basuca* or "crack" which is smoked.

Basuca is a stimulant substance produced in the transformation process from coca leaves into crystallized cocaine. It is not water soluble. It has a higher melt point than processed cocaine and it's absorption is more rapid. It contains cocaine alkaloids, residues of solvents used in preparation (gasoline, ether, kerosene), street cuts (baking soda, talcum powder, cereal), 40 to 85% sulfate of cocaine, and approximately 14.6% pure cocaine. Statistics indicate that more crack is consumed in Colombia than marijuana.

Illicit Trafficking Trends

Due to the great amount of money that the narcotics traffickers count on, they seek multiple modes of transportation to bring the drugs to the center of consumption for major economic utilization.

There is an intentional use of airplanes and ships with superior grades of technological equipment that provides them a safe and rapid means to transport drugs to their destination.

There has been significantly improved methods of smuggling. For example: to use flowers, ceramics, art works and to have Mules (people needing money) hide drugs on their bodies, in clothing or luggage. In addition, the re-appearance of opium poppy cultivation in rural areas is causing some alarm in Colombia.

With all that has occurred, the national government has not gone back on its promise to continue an intense frontal attack against these forms of trafficking. Through collaboration among organizations and institutions in charge of halting drug traffic (Department of justice, police, national guard, immigration and naturalization department) there has been an impact which has been commended by President Ronald Reagan of the United States.

We are concerned that the fight to halt drug traffic cannot remain solely within the confines of government. Drug rehabilitation programs, treatment and prevention efforts are necessary.

Prevention, Treatment & Rehabilitation

Colombia's first lady, Rosa Elena Alvarez de Bentacor, heads our National Commission on Drug Abuse, and, in conjunction with the ministries of Health, Justice and Family Welfare, has started a campaign for the prevention of drug abuse. A general policy to avoid the use and abuse of drugs which produce physical or psychological dependency is advocated. It is emphasized that the people should adopt these preventive measures.

Dr. Josefina Gallardo del Parejo has established "Nuevo Amanecer", a TC similar to the "TC of Colombia" run by Father Marco Fidel Lopez. There have been positive results from 14 centers specializing in drug and alcohol abuse throughout the country. At the same time, the Ministry of Health has been given the task of controlling prescription drugs that can be abused. Physicians should prescribe these drugs on special prescriptions with copies that are sent to the Ministry of Health.

The national government has begun to control the distribution and sale of products that are necessary in the preparation of cocaine free-base, as well as air traffic control and cancellation of pilot's licenses for those involved in drug trafficking. Colombia has obtained collaboration from other nations for fiscal assistance, specifically the United Nations Fund for Drug Abuse Control. Colombia has also initiated a program of crop substitution for cocaine cultivated in traditional zones like Narino and Calica. This program has as its objectives the production of food, the creation of commercial or cooperative farms, the introduction and development of the use of mechanical farm equipment, and to improve the quality of life for Colombian farmers.

Another prevention project is training and education in the formal and informal educational system. Prevention through the use of television and radio, information and data banks are being utilized as alternatives in treatment and rehabilitation.

In Colombia there are approximately 55,000 acres cultivating marijuana and a comparable amount cultivating cocaine. It is impossible to successfully eradicate or cut cultivation through the method of "gufosato" of fumigation.

Columbia has presented new legislation subscribing to an assistance agreement with various countries and cooperation among customs in these countries concerning control, repression and prevention of the trafficking of drugs and psychotropic substances. The legislation is designed to provide information and to approve an agreement to enforce imprisonment and/or the death penalty for illegal drug trafficking.

The Colombian government has decided to continue the fight against narcotics traffic. We will be in a better position to listen to suggestions, plans and programs allowing for improved efficiency. We implore the participants in this Ninth World Conference of Therapeutic Communities to convey and realize the recommendations stemming from this event in our countries of origin.

THE COUNSELOR'S GUIDE TO CONFIDENTIALITY: A REVIEW

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TITLE: *The Counselor's Guide to Confidentiality*
AUTHORS: Christine D. Weger, Esq. and Richard J. Diehl, Esq.
PUBLISHER: Program Information Associates, Honolulu, HI, 1984, 98 pp.

Attorneys Weger and Diehl have written an excellent guide for all of us who deal with confidential records of alcohol and drug abuse patients -- a practical tool for both lay people and attorneys.

Admittedly I approached the guide with a certain skepticism. Attempts to please both lawyers and their clients are either so technical that they convince the nonlawyer to retain counsel or so general that the lawyer deems them literary negligence. *The Counselor's Guide to Confidentiality* (hereinafter referred to as *The Guide*) is a rare instance wherein authors have sailed safely between Scylla and Charybdis, skirting both dangers and satisfying all. The rules and regulations are clearly explained in every day English for the generalist and amply supported with citations and references to give counsel all he or she will need to represent his client.

The Guide is more akin to a pamphlet than a book (apologies to those unprepared for a "pamphlet review"). Its 54 pages of narrative and 44 pages of appendix are typed rather than typeset and stapled together with a paper cover. The small size and light weight make it convenient, easy to keep handy, and easy to carry.

As an attorney I feel that the inclusion of the regulations (42 CFR Part 2) is a thoughtful addition, permitting the reader to consult the regulation itself while reading the authors' interpretation. Particularly helpful is the rich use of the legal opinions of the General Counsel of the Department of Health and Human Services. These are the opinions that count. If you've sought and relied on an official opinion of the regulatory agency administering the law you've acted in good faith, which goes a long way with most courts. The authors were thoughtful enough to also provide titles of publications containing these opinions, an address to write to for an opinion on a problem you may have, and even the phone number of the H.H.S. General Counsel.

Both counsel and generalists will also appreciate the H.H.S. approved forms that had been included. A form for a Qualified Service Agreement (QSA), a consent to release information, and a court order are provided. The authors might consider adding motion papers to quash subpoenas; they are available from the Legal Action Center in New York. Unlike consents and agreements you usually don't have much time to draft, a ready form could be crucial.

Weger and Diehl dedicate a chapter to a discussion of some of the common situations we all confront. Those of us who work in both treatment and criminal justice should appreciate the section on Disclosures to Law Enforcement Officials as well as the H.H.S. guidelines on how to handle requests from law enforcement officials for information about patients. I recommend The Guide for those working in TASC (Treatment Alternatives to Street Crime) or pretrial services programs throughout the country.

The thorny issue of child abuse disclosure is another of the common issues reviewed. An engrossing inspection of the "catch-22s" and dangers to avoid makes for good reading. So engrossing was this section that I sought out additional articles on the subject and in doing so unsettlingly found that the authors omitted an H.H.S. ruling reported by the Legal Action Center in New York permitting treatment programs to report child abuse "without written consent or court order if such a report can be made without identifying the abusing parent as a patient in alcohol or drug abuse treatment." This would be applicable to any institution that is involved in more than just drug or alcohol treatment, such as a hospital. One can't cover everything, and perhaps this will be corrected in the next edition. I hope so because it was just a spot check and it was an important bit of information to many of the programs.

No matter how monumental, penetrating or sublimely written a book (or pamphlet) of law may be, its most practical virtue is that it is current. *The Guide* is the latest word on today's law but not for long. As the authors point out, H.H.S. is currently in the process of revising the confidentiality laws. A section on the proposed changes detailing the alterations under consideration along with the mailing address and phone number of the legal assistant presumably working on the changes at H.H.S. is thoughtfully included. In speaking with Richard Diehl, I learned that they intend to publish a sequel should the laws change.

Those interested in obtaining a copy of *The Guide* are encourage not to discard this review after ordering. A fatal omission in printing left out the address of the publisher from the first edition. Diehl believes that a forthcoming second printing will contain their Hawaii address. Let's hope so, because I believe that it's going to be a guide in demand.

Weger and Diehl's guide is an ambitious and successful effort to pull together the regulations, court decisions, and administrative opinions into a compact and readable form. Other articles and pamphlets do exist, but none, to this reviewer's knowledge, has included all the essential material or references to material that both practitioner and counsel need to do their job. *The Guide* is a job well done.

CHAPTER 8

WOMEN, FAMILY SYSTEMS & THE TC

FAMILIES IN THE EIGHTIES

Reverend Cecil Williams

Glide Memorial Church
San Francisco, California

It is apparent to me that we are now moving from where we need to come from because I'm convinced that what we saw in the 70's created real havoc for us -- real problems. We were so caught up in narcissism, so caught up in gazing at our navels saying that I'm concerned about just me and that's it. But now in the 80's we're breaking out again, back into the world where the gutsy issues are. Therefore it is my own feeling that what we must do now is invent, create, to rightly understand then, for me, what we are facing here.

And this is the issue: that we must create from death. You ask Bishop Tutu and you ask the black South Africans what they have to live with every day and immediately they would say, "Death." Ask the people of Central America what they have to relate to and they would say, "Death." But you see, I'm convinced that you create from death. I was fascinated, literally, by the protest marches in South Africa and you could see the creation and the vision that was occurring from the funeral processions. People began to be ingenious enough to protest, to keep the issue before the South African government and before the world.

Now, what I really want to say is, too many times we get stuck and caught in our own situations, and what happens to us is that we hit a groove and the groove seems to be working and it sounds good and the rhythms create those things by which it feels like we're really on top of the situation and in control of the situation. But we settle down. And when we settle down, then we settle out. I'm here before you to say that, for me, every moment must be lived fully. Therefore, this is the most important moment for me. And the next moment will be important, too. But I'm not there yet. I've got to wait until I get there.

So therefore, everything that I have I give to this moment, to this experience. Because out of this experience we may be able to invent something new for humanity. Therefore it seems to me that we cannot settle in because we may settle out. What we must do, then, is be able to say, "Yes. There is power in death." Most of us have still not learned, however, the power that we can use when we say, "Yes," and also the power that we can accumulate when we really want it. A lot of people at my place are still afraid of power because, in many ways, to a lot of people power means that you become egotistical. It's bad to have a ego. You should have seen me when I didn't have an ego. And now I've got one and they say, "He's braggadocious." Yeah, I am, because I've got power now to overcome anything I want to overcome if I really want to overcome it.

Some people are so good they ain't good for nothing. And what we've got to do is invest some more "yes" power, to be able to affirm each other as well as ourselves, to be organized and bring together people, families, young people and people who are on the edge and people who have to live on the edge and people who find themselves what one might call the wretched of the earth. It seems to me that there are those of us who are going to have to live with the wretched of the earth for the rest of our lives. As so therefore we must get back from the edge.

A lot of folks want to go to the center. I'm saying to the people in the center, "You've got to come to the edge." If you really want to understand and respond to the poor of the world, if you really want to do something about the issues of oppression, the issues of starvation, if you really want to deal with the issue of people being drugged out and drugged in, if you really want to deal with the issues of how families find themselves desperately seeking some way by which they can come together again, then you've got to come to the edge. And find it. And say yes to that power. To say yes is to have the power to do several things, to take action, to do something. And the real issue here is that we talk too much about what we're going to do and we don't get done what we need to get done because we keep on talking about it. What you've got to do is get it going first, and then talk about it.

You will learn by the way we teach. So what they do is put memory in the minds of people so all they do is memorize and put it back on paper and give it back to the professor. What we've got to do is live our own stuff, which means what you've got to do is do it for yourself. Therefore you've got to do it. And if you do it and then you come back and reflect and talk about it and put it on paper, put it wherever you've got to put it so you can say it again. You've got to be able to tell your story, but you can't tell a story if you haven't enacted a story. You've got to do it. I know that doesn't set well with a lot of people.

It reminds me of 20 years ago when there were 60 people in the church and I said to them, "You know, I'm going to take down the cross." And they said, "You're crazy. You would never do it." I took it down and I got a jazz band and I got a lot of people to show up. And the people were crowding into my place because what I did was, I said to them, "I'm not going to be a traditional church." And they said, "We wouldn't expect that from a black minister." And I said, "I'm not a black minister. I am a minister who is black who's going to chance the whole issue here and bring some soul into this church."

So we must be able to use the power of death and that means that we get to create life. Don't lock yourself in. These are exciting times. We can begin now, or we can just let it go.

WOMEN, WORK AND SUBSTANCE ABUSE

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A comprehensive examination of the problem of chemical dependency among employed women that is solution-oriented must deal with three primary sets of data: 1) facts about women's chemical dependency; 2) facts about women's working lives; and 3) information about the relationship of women to employee assistance programs (EAPs).

Significantly, an examination of the three sets of data indicates that the profiles of women as workers, as substance abusers, and EAP consumers, differ substantially from those of men. This paper will examine the three sets of data indicated, thus exploring salient features of women's lives as workers, and as substance abusers, and the relationship of women to Employee Assistance Programs.

The basic purpose of the paper is to cull from facts concerning women's chemical dependency, their work lives, and their relationship to EAP programs directions for the development of prevention programs and effective new EAP models especially addressing the treatment needs of chemically dependent working women.

A final analysis/recommendations section of the paper will attempt to integrate information from the three areas considered to arrive at recommendations suggesting directions for development of effective employee assistance program services for women.

Women and Chemical Dependency

Salient facts concerning women and chemical dependency include the following:

1) The roots of the double standard taken towards women's chemical dependency are both ancient and still powerful today. In ancient Rome a man was legally permitted to starve or stone to death his wife if he smelled wine on her breath, since her drinking was considered a precursor to adultery. The Roman wife could not similarly punish her husband for his drunkenness.

2) The double standard taken towards women's substance abuse is still operative in the U.S. in the 1980's. This prejudicial attitude towards female substance abuse often seriously interferes with a woman's being able to admit that she is chemically dependent. Thus, it severely impedes the woman's ability to take effective action against a life-threatening problem.

3) The double standard adopted towards women's chemical dependency is probably reflected in the fact that chemically dependent women, unlike men, are very frequently abandoned by their spouses.

4) Substance abuse literature reports that women are especially vulnerable to the positive or negative influences of "significant others" in development and maintenance of or recovery from chemical dependency. Relevant literature, for example, states that:

- Women are, with very great frequency, introduced to drugs by a man--usually a spouse or boyfriend--who is often also involved in the woman's continuing drug use. Chemically dependent women receiving positive support for treatment from a husband or close male friend, however, have higher recovery rates than women who don't receive this support.

- Society's double standard evaluation of the chemically dependent woman encourages many families to deny the female family member's chemical dependency. Family denial reinforces the woman's personal denial of the problem. Because of the profound role that families can play in supporting or undermining recovery, a currently preferred confrontation strategy in working with chemically dependent women is to confront the woman about her substance abuse in the presence of family members.

- Chemically dependent women appear to experience considerable guilt concerning the impact of their addiction on their role as mothers and wives. Many express concern that their substance abuse will harm their husbands' reputation and social standing.

- A major Odyssey House study found that 44% of women in treatment in the program, at a certain period, were incest victims. Developmentally, significant others also appear to be powerfully associated with women's substance abuse.

- Recent alcoholism research indicates that daughters of alcoholic parents are at higher risk for chemical dependency than any other known group.

5) New York State Division of Substance Abuse Services data indicates that providing good health care services, including gynecological and obstetric care, is highly correlated with retaining chemically dependent

women in treatment. Child care programs also seem to significantly support recovery of chemically dependent women.

6) Although use of psychotropic drugs is consistently higher among women while men more often use alcohol to self-medicate for stress, drug taking habits of the young of both sexes, both in terms of the percentages using drugs and types of drugs taken, are becoming more similar.

7) Chemical dependency literature more often profiles chemically dependent women than men as suffering from secondary mental health diagnoses, especially anxiety neurosis and depression. The presumption of the more frequent or severe mental health problems of chemically dependent women has been called into question, however, by some studies calling for substance abuse researchers to be sensitive to stereotyped notions of masculine and feminine behavior biasing the observations, theories and theoretical perspectives of their studies. A greater societal readiness to perceive women generally as more mentally unstable may also partially account for the hypothesized greater mental health pathology of chemically dependent women.

8) Although considerable substance abuse literature portrays female addicts as having low self-esteem and a poor image of their sexuality and sexual attractiveness, it has not been conclusively established that these characteristics are more typical of chemically dependent women than men. These findings may be partly an artifact of the double standard taken towards female drug abuse. It seems clearly established, however, that substance abusing men and women share many important similarities. Many alcoholic men and women, for example, report distanced parent-child relationships, dependency problems, and a history of using alcohol to escape internal and external stress. Women, those chemical dependency is generally more harshly judged by society, may, not surprisingly, be more likely to experience guilt and depression concerning their substance abuse.

The Relationship of Women to Employee Assistance Programs

The following are salient facts concerning the relationship of working women to employee assistance programs (EAPs):

1) The Women's Drug Research Coordinating Project suggests that the process of addiction, definition of social productivity, and social roles and relationships generally differ for women and men. If this is so, women's relationships to employee assistance programs could be expected to differ, even significantly, from men's.

2) EAP literature suggests that many companies and supervisors hold female employees in generally low esteem, do not take them as seriously as male workers, and don't expect a similar level of performance from them. Women's relationship to employee assistance programs should be impacted by these attitudes.

3) EAP data consistently reports that a lower percentage of substance abusing female employees are reached by company and union employee assistance programs. Yet female employees represent both a large potential market as direct consumers for EAP services because of their substance abuse and other personal problems leading to work impairment. Working women also represent a large market for EAP services because of their children's substance abuse and the high proportion of women married to substance abusing men.

4) Some recent EAP literature suggests that there may be a generally stronger distrust of work organizations by female than male employees. This distrust may be associated with the demonstrated lower utilization by women of employee assistance programs.

5) EAP literature consistently cites greater reluctance by both male and female supervisors to confront female employees about generally impaired work performance or concerning suspected substance abuse. Reasons given by supervisors for this reluctance include women's greater sensitivity, tendency to take confrontation as an affront; tendency to use personal problems as an excuse for non-performance, and susceptibility to crying.

6) Survey data indicates that both male and female supervisors admit ignoring female job performance problems longer due to fear of the woman's reaction to being confronted. In line with this self-report data, men and female supervisors do, in fact, less often refer female than male employees to employee assistance programs.

7) A prime external factor associated with lower utilization by women of employee assistance programs, however, stems from women's different fit into work organizations. Women's generally lower job status and fewer fringe benefits, more frequent part-time and temporary job placement, and unemployment in organizations employing under 20 employees are associated with women workers' more limited access to health care plans and to employee assistance programs.

8) Employee Assistance Programs in the United States, although undergoing changes, are still male model programs. The greater number of employee assistance programs are administered by males, were designed by males for male clientele, and are more successful in outreach efforts to male than female employees.

9) The pervasive underemployment of American women seems to serve as an obstacle to employee assistance program casefinding among non-professional, non-management level women employees. Many women report being able to perform adequately on their jobs despite their addiction or alcoholism.

10) The structure of management positions does not seem to interface well, for either sex, with the employee assistance program model. Women who move out of lower status, low autonomy and closely supervised jobs, like men, appear to be at greater risk for substance abuse.

11) While employee assistance program literature indicates that absenteeism is a good indicator of both female and male occupational impairment below management level, this literature suggests that deterioration in personal appearance can be a particularly helpful cue to occupational impairment in women.

12) Chemical dependency literature suggests that specific stressful life events more often trigger women's than men's substance abuse.

13) Research findings indicate that female employees who do enter treatment through contact with an employee assistance program have almost as high a recovery rate as male employees referred through the employee assistance program.

Profile: Women as Workers

The Labor Department provides the following key facts about women workers in the United States in the 80's:

1) 47 million women , or 43% of all workers in the United States are women.

2) The average full-time woman worker earns 59% of the average male worker's earnings.

3) The majority of women work because of economic need. Two-thirds of all women in the labor force are single, widowed, divorced, separated, or have husbands earning less than $15,000. These women work because they must.

4) Women represent 63% of all adults below the poverty level.

5) The unemployment rate is lowest for adult white men and highest for young black women.

6) The average woman worker is as well educated as the average man; both have completed a median of 12.7 years of schooling.

7) The more education a woman has, the greater is the likelihood that she will seek employment.

8) Women with 4 or more years of college earn about the same income as men with 1 to 3 years of high school. Women high school graduates who are fully employed earn less than men who haven't completed elementary school.

9) 66% of all part-time workers are women.

10) Women are concentrated for the most part in low paying dead end jobs. 60% of all clerical work3ers are women versus 6% of all craft workers. Women constitute 62% of service workers but only 45% of professional and technical workers; women constitute 63% of retail sales workers but only 28% of non-farm managers and administrators.

11) The average woman workers is 34 years old and can expect to work for 18 additional years.

12) 70% of women 20 to 24 years old work. There is a strong national trend for labor force participation to be highest among younger women.

13) The influx of women workers into the labor force in the 1970's has resulted in nearly equal labor force participation rates for women by race.

14) Women account for 60% of the increase in the civilian labor force in the last decade.

Working Women and Families

1) Two-thirds of persons living below the poverty line are women. In 1983 more than one out of every three families maintained by a woman was poor as compared with one of 13 other families.

2) The median income for families headed by women was $15,080 in 1984. The comparable figure for families headed by men was $23,400.

3) The number of working mothers has increased more than tenfold since the period immediately preceding World War II while the number of working women has more than tripled.

4) 59% of all women with children under 18 years of age are in the labor force. 50% of mothers with preschool children work.

5) Women are maintaining an increasingly large proportion of all families--16% in 1982. A significant proportion of these families subsist at incomes below the poverty level.

6) 70% of poor black families are headed by women. 50% of poor Spanish families are headed by women. 39% of poor white families are headed by women.

7) Most employed women maintaining families have tended to remain in the generally low paying or less skilled jobs. Like most employed women, the largest proportion of those maintaining families were in administrative support jobs, including clerical work.

8) Characteristics of women workers who head families include higher unemployment, lower educational attainment, more dependent children, and lower earnings when compared with other labor force groups. These characteristics explain in part the high incidence of poverty in families maintained by women.

9) Most employed women maintaining families worked at full-time jobs in 1984--82%. Those aged 25 to 54 were more likely to be working full-time (85%) than either younger women (72%) or older women (75%).

The basic message of these Labor Department women's and family statistics is that more women work--that very large numbers of American women have very quickly entered the labor force.

A second important factor complementing the quickly increasing participation of American women in the labor force is the fact that more women have to work--because they live independently and must maintain themselves; because they need to supplement low family incomes; and often because they are the sole support of children.

A third important fact of American women's work life is that women who work earn considerably less--only slightly over half of what their male counterparts earn. This is true despite the fact that women, as a group, are as well educated as men. Women's degrees, however, translate into very much less income than do men's. Women college graduates earn what male high school dropouts earn. Women with high school diplomas earn less than male dropouts from elementary school.

Significantly, too, women generally have less seniority and less job security than men. Women are historically unemployed at higher rates and are less able to collect unemployment compensation than men.

Women are under-represented as union members and over-represented as part-time employees. Consequently, women have less access to employment benefit packages and to job protections.

The bottom line of Labor Department statistics on women and work are the salaries paid to women and the kinds of jobs women are trained for, conditioned to accept, and hired to fill. Women are still concentrated in dead end low paying jobs. This is the basic fact of women's employment.

The other, very significant aspect of Labor Department family statistics for working women is their clear delineation of a rapid and sharp increase in the number of families maintained and supported by women--a rise not matched by an increase in women's earnings.

Trends Concerning Women and Work

Trends concerning women's status in the labor market present a complex and contradictory picture. There are many indications that things are and will get better for working women, but there are also strong new negative trends.

Positive Trends. Positive trends and gains for women workers include:

* An increase in women's overall employment despite downward trends in the U.S. economy;

* Penetration by a certain percentage of women into occupations formerly almost completely closed to women, especially in high paid professions and blue collar jobs;

* Educational advancements by women, at least at the upper ends of the educational scale; and

* Legislation attempting to guarantee women equal opportunity in employment.

Downward Trends. The following are four major trends inhibiting the quality of women's status as workers and the gains in employment that women have recently been attempting to make.

- The increasing feminization of poverty, i.e. an accelerating trend through which women and their dependents are overwhelmingly becoming the poor in the United States. The major factor behind the upsurge in female poverty, however, appears to be the phenomenal increase in women raising families alone. There were 8.5 million women raising families alone in 1979--an increase of 30% in just nine years;

- Cutbacks in publicly funded employment and training programs;

- Weakening of equal opportunity and affirmative action mandates that remove incentives to hire women;

- Automation of office work that threatens to eliminate jobs held by the majority of women office workers.

The U.S. Department of Labor's assessment of major obstacles facing working women include the problems of 1) access to the full range of existing jobs; 2) women employee's low pay rates; 3) stress because of women's dual roles at home and at work; and 4) women worker's need for various forms of counseling, family support systems, and flexible work hours.

Analysis and Recommendations

The following recommendations for adoption of and changes in employee assistance programs are made with the end in view of 1) increasing the number of referrals to company any not work equally well for both sexes. Thus, if industry does not wish (and is not structured) to maximize a high level of functioning from female labor, it is doubtful that a work impairment supervisory intervention mode will be an optimal tool for casefinding chemically dependent women workers. If female workers are more valued as a source of cheap labor, or as a labor underclass, than as workers functioning up to capacity, chemically dependent women workers will be able to easily hide thintersect with women's underutilization of employee assistance programs is in the design of the programs. The currently most favored EAP design--the work impairment/supervisory intervention model--appears, for some very basic reasons, to have limited effectiveness in reaching chemically dependent and otherwise occupationally impaired women. If, as the Women's Drug Research Coordinating Project suggests, definitions of social productivity are quite different for women and men, this model may not work equally well for both sexes. Thus, if industry does not wish (and is not structured) to maximize a high level of functioning from female labor, it is doubtful that a work impairment supervisory intervention mode will be an optimal tool for casefinding chemically dependent women workers. If female workers are more valued as a source of cheap labor, or as a labor underclass, than as workers functioning up to capacity, chemically dependent women workers will be able to easily hide their occupational impairment under cover of their under-employment. This is, in fact, what research indicates often happens. Many women workers report being able to perform adequately for long periods of their jobs despite their chemical dependency.

To solve the problem of women employees and the supervisory intervention EAP model raises both many complexities and possibilities.

First, pervasive female under-employment, which stands as a significant obstacles to usefulness of the impaired worker performance EAP model, can be addressed by government and individual businesses on an affirmative action, employee placement, and job design level. Addressing the problem of female under-employment head-on is a grassroots approach to the related problem of women's fit into employee assistance programs.

Second, various modifications to the traditional supervisory intervention/impaired work performance model should be considered. The modifications can be basic structural changes or small changes such as use of symptoms and other criteria in addition to work performance deterioration as a signal to supervisors of a possibly troubled employee.

Finally, new models, radically different from the supervisory intervention/work performance EAP model, should be considered in the attempt to reach more occupationally impaired women.

The supervisory intervention employee assistance program model appears to have generals limited usefulness with male and female managers and executives. Women who are able to move out of lower status, low autonomy, closely supervised jobs appear, like men who attain higher level positions, to be at greater risk for substance abuse. The supervisory intervention model appears to be rather ineffective in casefinding among this population. Former male and female chemically dependent executives both report having been able to rearrange their work schedules around their drug dependence or alcoholism so that obvious signs of work impairment, such as absenteeism and lateness, did not surface.

Although women managers, like men, commonly gain autonomy, which can camouflage chemical dependency, from managerial job titles, women managers' chemical dependency appears to be doubly hidden due to the fact that even as managers they are often underemployed.

The EAP model based on supervisory intervention due to signs of deteriorating work performance would thus appear to be a problematic tool for reaching chemically dependent female managers and professionals. To compound the problems of EAP outreach to the chemically dependent woman manager, the peer intervention model, sometimes used alternatively to the supervisory intervention model, is more difficult to utilize with women managers than with men because networking systems for women managers are much rarer, and less developed, than those for men.

Present data strongly suggest that the supervisory intervention/work performance EAP model is an inappropriate or ineffective tool for assisting chemically dependent women managers. Successful adaptation of the peer intervention model to this population appears to be a more viable outreach strategy. Successfully adapting the peer intervention strategy to women managers will require management and unions to lay a foundation leading to stronger networking among women in higher level business positions.

Women's greater participation in the nation's health care system suggests that if employee assistance programs are adapted to meet women employees' needs, they will be successful in reaching this target population. Although EAP program designers and administrators may have to deal for some time with female reluctance to admit substance abuse because of the greater social stigma placed on women for this behavior, these double standard referral losses should be balanced by gains associated with women's generally greater willingness to be open about health care needs and their willingness to accept help from others.

Since family members and significant others have been shown to play a very large role in women's development and maintenance of chemical dependency, both strategies to bring women into the EAP program and treatment strategies for the female EAP client should contain a strong focus on family and significant others. Family members and significant others should be engaged in the women's treatment, wherever this is feasible, and not contraindicated clinically.

Women's extensive participation in the nation's health care system suggests that an effective location for employee assistance programs seeking greater outreach to female clients is within a medical unit structure. Seminars on health topics of particular interest to women can serve as excellent vehicles from which to obliquely approach the subject of women's substance abuse. Health topic seminars serving as vehicles to introduce the topic of chemical dependency to women workers could include:

P.M.S. Blues
Women and Stress
The 24-Hour Day: Wife, Worker and Mother
Vocational Planning and Counseling
Adolescents and Drugs
Marriage Maintenance
Return to a Career after Raising a Child
The Middle of Life: New Vistas
Weight Reduction
Money Management
Exercise and Health Care
Nutrition
Singles' Lifestyle
Single Parenting
Building a Career
Job Advancement
Women's Networking
Money Management
Coping with Loss

Because of women's generally stronger home and people orientation, employee assistance programs that wish to be successful in attracting chemically dependent and other occupationally impaired women need to become well established in the workplace in a quite personal way. The employee assistance program should gain a reputation in the workplace as 1) a place to go to: a place which is accessible, special, warm, caring, but confidential; and 2) a person to go to: the EAP manager or counselor needs to become established as a well-known, trusted, and liked person.

Research in the EAP field has demonstrated that presence of a woman on staff is a major factor in increasing program outreach to women. The advantages of the identification factor are obvious. Additionally, considerable research indicates that many chemically dependent women have experienced child abuse and other difficulties in sexual or sensitive areas that may be easier to broach with a woman counselor. Staffing more employee assistance programs with women is likely to provide impetus for more female self-referrals to the program.

Employee assistance programs that provide important and needed services to women, in addition to traditional alcoholism and drug dependency counseling, should achieve higher utilization rates by chemically dependent and other occupationally impaired women. Counseling services which the EAP can provide for women employees include:

- Career and vocational counseling including counseling concerning promotional opportunities and possibilities within the work site and the training or background required to be a candidate for specific positions.

* Financial counseling.

* Assistance for women needing to coordinate work hours with child care and other family responsibilities.

* Legal referral service.

* Exercise classes.

* Weight reduction and nutritional counseling and planning.

Employee assistance programs that wish to increase outreach to chemically dependent and other occupationally impaired workers should be able to reach this goal by addressing some of the central problems which women worker's face, including the considerable gap between women's educational backgrounds and their job status and salaries. The employee assistance program can do this by providing ongoing vocational and career counseling and/or seminars on these topics. The threat to job security that automation poses to the very large proportion of women who are clerical workers, for example, can be reduced by the employee assistance program providing seminars on the topics, referrals for re-training, and sponsorship of training in latest office technology. These "extra" EAP services can also include counseling to help women effectively mobilize current training and experience to attain promotions or higher paid work within their present work organization. The "EAP extras" can justify their expense by assisting companies gain greater trust of women employees (a troublespot mentioned by EAP literature), lead to greater numbers of women referred to the EAP program and also provide a much needed service for women employees.

A promising suggestion of Harrison Trice's recent work with women and EAP's is the idea that EAP administrators and researchers can take advantage of the fact that women workers are highly concentrated in a few "traditional occupations." EAP developers can work with the unions and trade associations associated with these "women majority" industries to reach chemically dependent and other occupationally impaired female employees.

Media promotion of EAP's can easily be changes so that it's more likely to be attractive to a female audience. Such simple changes as representing women on EAP posters and advertising and using the feminine as well as masculine pronouns, would be a first step toward doing this. Designing EAP-sponsored seminars of special interest to women employees would be an intermediate step.

Due to the very demanding household and childcare responsibilities which many working women hold, EAP's need to carefully consider scheduling time for EAP outreach activities and treatment for women personnel. Scheduling these activities and treatment itself during the lunch hours or during work hours release time may prove more feasible than scheduling them after the work day ends.

Employee assistance programs need to provide ongoing training for supervisors which addresses the needs of chemically dependent women employees and which also addresses problems supervisors come to experience in confronting and referring women to employee assistance programs.

NATIONAL FEDERATION OF PARENTS

Shirley Colletti

National Federation of Parents

The National Federation of Parents was organized in May of 1980. We opened our offices in Silver Spring, Maryland in February of 1981. We are in communication with over 8,000 parent groups throughout America and network with many national organizations such as the Parent Teachers Association (PTA) and National Association of Broadcasters.

We encourage the parent groups to involve themselves in their children's circle of friends and their parents. As your child begins to become more independent, we encourage our parents to become more involved. The parent movement is really a type of empowerment model --the same model many of our parents and grandparents practiced.

TCs can play an important role in assisting the development of the patent movement. We must use all of the expertise that we have gained over the years to help the parent group that has formed or may be forming in our communities. True prevention of drug and alcohol abuse must start in the home. When many of us were developing treatment programs 15 years ago, we realized the need for parents to involve themselves in the drug prevention effort. Unfortunately, a great deal of denial and fright existed in them,and we were not successful in recruiting parents into our fight.

Today, however, we are on a new frontier. We have parents, schools and communities looking at the community based treatment programs, such as therapeutic communities, for leadership in areas of drug and alcohol education. I say leadership, but not ownership, because if the parent movement is to thrive, we must allow and encourage the ownership and, yes, the work to stay with the parents. For too long we have seen families look to us to fix the child, and you know and I know this doesn't work.

The fix the child syndrome has encouraged a proliferation of miracle cure 28-day programs across the country. It is my belief that many of these programs are duping and misleading parents into believing that their child will be fixed if we will just leave the youngster for as long as the insurance holds out. What happens then? You guessed it.

The National Federation of Parents is rapidly becoming viewed as a potent force interfacing with Congress and legislatures around the country. I believe that most of our programs have had to spend so much energy on funding issues and just plain survival that the important legislation for change has not been dealt with. The NFP is joining with other constituency groups to educate legislators and decision-makers, and we are beginning to see some achievements in state legislatures and in Congress.

The parent movement is in its infancy and is still having growing pains as you all did years ago. Join in the movement because, after all, aren't most of you parents?

THE PARENTS' ASSOCIATION IN AUSTRALIA

Ian R. Permezel

Odyssey House
Victoria, Australia

Therapeutic communities in Australia tend to follow the American model and our therapeutic community is based on the Odyssey program. The Odyssey program has been developed over an 18-year period through the thought and the effort of the American psychiatrist, Dr. Judianne Densen-Gerber. It is now established in five American states, in two Australian states and in the two islands of New Zealand.

A parents' association is attached to each Odyssey program, and these associations are linked but are not in any way part of each treatment program.

In Australia, the two Odyssey Houses have an overall resident population of 300 persons. These two houses are 500 miles apart and each parents' association has a slightly different name and a slightly different mix of people.

I will talk about the Melbourne Odyssey House and its parents' association. First, an overview of the parents' association.

In Melbourne, this association is almost six years old and it has a membership of approximately 150 parents and special friends. About 100 people regularly attend the monthly meetings.

The association is a properly constituted group. It holds annual general meetings, it elects office bearers and it makes presentations of accounts. The main aim of the association is to give support to the parents who have sons or daughters in the therapeutic community.

The leadership of the association has been good, capable and caring. The membership is open to all parents, relatives and friends, and the payment of a membership subscription is quite voluntary.

The parents' associations' source of funds is mainly from the membership subscriptions plus some fundraising activities, firstly to provide a Christmas luncheon for the residents of Odyssey House and, secondly, to purchase some special pieces of equipment for the House as the need arises.

The meetings of the association are properly conducted and comprise three parts, each with a district education component.

a) There is always a guest speaker on a therapeutic community related subject such as treatment aspects, medical topics, legal concerns, etc.

b) Speakers from the therapeutic community, usually senior residents, explain the nature of the therapeutic community and the various stages or levels which form the structure of that community. These speakers also make themselves available to talk to the parents after the meeting and are always engaged in a vigorous question and answer session.

c) The final part of the meeting usually comprises socialization and the sharing of experiences in an informal and unstructured way.

In a recent survey of parents, no one wished to change the simple format of the meetings as they found it a satisfactory way to acquire knowledge of the therapeutic community and to socialize.

Between meetings of the association, members are encouraged to contact a small group of experienced parents who are available to discuss any personal problems relating to their sons or daughters in residence at Odyssey House.

The parents of the residents are also encouraged to keep contact with the staff of the therapeutic community and, at the appropriate time, to make contact with their son or daughter. But this contacting process is essentially a function of the therapeutic community and no the parents' association.

The Melbourne therapeutic community comprises between 150 and 170 people who are in long-term residents. The residents comprise adults, adolescents and drug-affected parents with their own young children. The age range of the residents in treatment is from 13 years old to 35 years old, the average age being 24. There are three males to every female.

The residents of our therapeutic community are made up of a broad cross-section of the local community.

a) There are varying levels of economic status represented from the wealthy to the middle class to the poor.

b) There is a range of people from various social strata.

c) There are many ethnic backgrounds represented spanning English, Italian, Greek, various Middle European, Asian and, of course, Australian.

d) There are many variations of educational achievement from primary levels to secondary and tertiary levels.

It is interesting to compare this profile of the resident population with the membership of the parents' association. How does it match? It is obvious from the above that the age range of the parents who come to the meeting will be very wide, from the early thirties to the late sixties, and this age range creates real generation gaps and some tensions. As you would expect, the parents of sons outnumber the parents of daughters on a three-to-one basis.

It might be expected that the same broad cross-section of the community which is represented among the residents is also represented among the parents. But this is not so. The parents who attend meetings of the association seem to comprise the middle ground of the economic scale, the social scale and the education scale. Those parents who are at the ends of the spectrum rarely seem to attend.

It appears that the wealthy and those with high social status are not anxious to be identified in a public way with drug addiction, and those who are educated above the average seem to have the view that they can cope on their own.

Those parents who are at the lower end of the wealth, education and social scale are often too poor to come to meetings, are too uncertain of themselves in a social setting and don't feel articulate enough to mix with those who have been better educated.

In those cases where the parents are the first generation in Australia and are non-English speaking, then their attendance at meetings is almost impossible unless accompanied by one of their children who then acts as an interpreter, often an embarrassing situation for them all.

The above reasons for non-attending result in a different mix of parents at the association meetings. The mix is also made different by those parents who do not attend for other reasons. There are those who do not attend because they really don't care. Often their son or daughter has caused them enough grief and trauma and they have had enough of the relationship. Then there are those parents who are alcohol or drug-addicted themselves.

Finally, there are some families where physical, sexual and emotional abuse by one or both parents has had a major impact on the lives of the family members, and those parents are less likely to attend. Where family members do attend in this category, they often dissociate themselves from the past.

As there are many reasons why parents do not attend the parents' association, there are also many reasons why parents do. In our recent survey of parents, the most common reason given for attending meetings is to gain support from people who have been, and are, in a like position. There is a relating to the same problems, a sharing of the same burdens, a coming to terms with the feelings of guilt. These parents are seeking friendship, understanding, are moving from "heartache to optimism." They seek a chance to talk.

Most of the parents have learned hard life lessons with a drug-addicted person in the house. They have stumbled on the pot, the needles, the powders. They have seen the changes which take place in the personalities of their children. They have watched the irregular sleep patterns, the missed meals, the total irresponsibility within the family, the large debts and the thefts, the police at the door and the courts.

And they want to tell the stories to one another about the confusion, the talking, the pleading, the contact with doctors and hospitals and health care agencies, the merry-go-round of well-meaning people, their own ill-equipped efforts, and the mess they made of their attempts to help.

Positive changes take place as parents learn about new ways to cope with drug-affected people. Looking back now, most parents say they would get help sooner, they would bring things to a head, they would say "no" to demands and, as one mother has said, "I would have much less respect for my daughter's so-called freedoms."

Of course, many parents are in a dilemma about the action they would take in the future. As one father said, "I would give less support to my son knowing what I know now, but the final decision would be based on keeping my child alive." A mother said, "I know what I should do, but I am a mother first and a logical person second."

As well as seeking support from one another, what else are these parents looking for? They want help when their sons or daughters split the therapeutic community. They want the courage and the confidence and the knowledge to be able to say, "Go back."

Nearly all the parents recognize that they have their own "coping with life" difficulties and that outside professional counseling would help. They would like the parents' association to help arrange that counseling. They would also like to help parents whose sons or daughters are abusing drugs, but who haven't yet found the therapeutic community. Most parents would be prepared to talk to those parents (but not to counsel) on a one-for-one basis. This is the beginning of a bridging process between the parents' association and the wider community.

And many parents would like to be much closer to the therapeutic community, to be more involved, to sit in on group sessions, to be part of the therapy process. The question is, "Is that closer relationship possible, and is it realistic?"

THE FAMILY ASSOCIATION IN AUSTRALIA: CLINICAL ASPECTS

Joe Lamberti

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The purpose of having this paper in two parts is to accentuate the fact that in our mind there are definitely two aspects to the relationship between the therapeutic community and its members in treatment and the Family Associations connected to that program. The first section by Mr. Permezel described the constructive and productive aspects of a Parents and Supporters interaction with the therapeutic community are both true and necessary. However, we did not want to confuse that with the very sensitive treatment issues involved in some of the more complex inter-family relationships.

In 1975, The Odyssey House Program in five different states in America conducted a research program focusing on the causative factors of drug addiction. At that time our figures showed that 70% of our resident population in those five programs had been victims of some form of overt child abuse, including psychological abuse, physical abuse or sexual abuse. In fact 44% of the women in the study were shown to be sexually traumatized within the family in their prepubescent years. These figures have been consistent over the years and a recent survey in our programs in Sydney and Melbourne, Australia show very close correlation with the studies conducted in 1975 in America.

Secondly, I would like to point out that it has been our observation that there are families who may not be overtly abusive but tend to be possessive, infantalizing and have a vested interest in keeping a child dependent. It is these types of families who tend to be the biggest saboteurs of a person's ability to complete the therapeutic community process.

It is for these reasons that we strongly believe that there needs to be, in some instances, an arms length relationship with clear separation between the treatment or therapeutic bonds between the residents and the staff and the program's relationship with the parents.

I would like to make clear at this point that we are not against family therapy and, in fact, recognize the necessity when appropriate for ongoing intense family therapy in order to treat the whole person and his or her environment in order to prevent continued drug abuse after the therapeutic community process is completed. It has been our experience in addressing the problem of drug related child abuse that there is a common pattern followed by the abused child in which they believe that they themselves are at fault for the abuse and that if they would be good girls and boys, mummy and daddy would not have to act out against them in such a way. This creates a syndrome in latter years where the abused child repeatedly returns to the family seeking positive recognition only to be met with continued abuse. Thus a cycle is developed, the more the abuse, the more the child needs to seek positive attention.

It is in cases like these that the therapeutic community must be able to allow a child to be an individual and grow up to be a responsible independent adult, developing appropriate distance and a respectful relationship with their family, without total pathological dependence. The therapeutic community must be careful not to openly go against the family, as this only results in panic and the person in treatment retreating completely away from the therapeutic community and following their instinctive loyalties to their family.

One example of this is the immigrant family where both parents were factory workers, the father working the nightshift and the mother working the dayshift. Due to language problems and an inability to negotiate the Australian school system, they "overlooked" entering their 6 year old son in primary school. This created a situation where the boy was left home unattended, with the exception of his father whose sleep was so important in order for him to continue his nightshift position. The way the family chose to problem solve this situation was to tie the boy with a length of rope to his father's leg for eight hours during the day, with only a bottle of milk and a loaf of bread to keep him occupied. If at any time he would go beyond the boundaries of the rope he was met with a rage reaction from his sleeping father.

In order for this young man to work through the love/hate relationship that exists with his family, he must first individuate and develop a bond with the program staff in which he can go through his ambivalent emotions first and then later develop the relationships with his family perhaps through family therapy.

The other example would be a typical incest family secret phenomenon. We have one case in our Australian program where the incest perpetrator in his attempt to maintain the family secret and loyalty relationship between him and his daughter (who is in the Odyssey House Program) continued to shower the program with large donations and exaggerated promises for the future. If the program was to actively embrace this family during the initial stages of the girl's treatment it would create a situation in which it would be almost impossible for the incest victim to feel free enough and safe enough to confide in the program staff with such accusations against the family.

It is in these kinds of situations that it is extremely important to be sure not to create a conflict of loyalty among the treatment staff and the people in their care. We must also be extremely careful not to create a sense of betrayal on the part of the person in the program. It is important that the people in the therapeutic community feel that the TC is their territory, their experience and their private relationship with the people who they open up their most inner secrets to. It must be in their control who and when other people receive the information that they divulge in the course of their therapy, including, and sometimes in particular, immediate family.

There seems to be a general naive belief that in order to complete therapy you must keep the family together at any cost. I can only emphasize that is situations where there is a pathological relationship, if at all, from that point. When you have a destructive family system you must allow the person in treatment to come to terms with it and cope through the surrogate family support of the therapeutic community, not to replace the blood family with the therapeutic community, but to allow the TC to become an additional family so that if the person in treatment chooses to be independent from their blood family, they have an avenue to do so. And it is our obligation to support them in this endeavor and impress upon them that it is their right as an individual human being.

THE CHALLENGE OF GROWTH AND CHANGE

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Back in 1966, the Daytop Village Family Association came into being. At first that small group of parents met whenever and wherever they could on Staten Island. With the acquisition of the first outreach storefront in 1967, parents began meeting on a regular basis on the lower east side of New York. Initially, family members assembled as a moral support to their residents, but it soon became apparent that these family members had feelings of their own to deal with--guilt, anger, fear, confusion, irresponsible love, etc. The question became, "What can be done for the parents of drug abusers? Hoe are they helped to grow and change? How does their growth and change, or lack of it, affect their loved one in treatment?" The answer--a family association!

A new member of the association goes through a very structured process of learning what the association is all about. In orientation, the parent has the opportunity to talk about fears, guilt, confusion, etc. Quite clearly, this is an educational stage. The education and learning continues from orientation to pre-encounter, to concept group and finally to encounter groups where they get the opportunity to deal with their feelings--to grow and change.

Over the years, almost 20 at this point in time, this procedure has helped thousands of parents and family members. Almost 20 years is a long time. The time span itself is a problem. The Daytop Village Family Association must be alert. Alert to what? For one thing, the parents of the 80's are very different from the parents of the 60's. Today's parents are the adolescents of the 60's. Their thoughts, ideas, and philosophies are very different.

We find many of today's parents are or have been involved with drugs themselves and see no problem with using drugs. What is our challenge? The challenge is the changing times and our ability to change with time--our ability to adjust our ways of getting through to the parents we are dealing with today.

How do we do this? We change the structure of our parent groups, i.e., we always believed that husbands and wives should not be in the same encounter group. Now we say, maybe they should!

We have adjusted our Ambulatory Treatment Centers so that the parent of an outreach member must attend parent groups at the Outreach Center, allowing the staff at the Outreach Center to work closely with those parents who have children attending on an ambulatory basis.

Our midtown headquarters is geared for the parents who have residents in a 24 hour therapeutic community setting. This gives us the ability to help these parents on a more personal level because they are different from the parent of an outreach member. We are currently in the process of developing groups for the parents of our adolescent residents. Their situation is also a unique one.

Another challenge that looms is what do we do for the parent who has been attending groups for three, four, five years? How do we motivate and stimulate interest? At Daytop, we have recently developed "specialized groups." Husbands and wives; a group for men only; women only; prejudice groups; groups for family members who have elderly ailing parents; members who have recently lost a parent. These groups are proving exciting sources for growth and change.

For the first time, this year, 1985, the Association reached out to touch the entire family of a drug abuses. We developed a program for Siblings Of Drug Abusers (S.O.D.A.). Thirty-seven youngsters attended. The sessions were not run as encounter groups, but rather a setting for them to express their feelings about their brothers or sisters in treatment; the therapeutic community--what it is and why. The three sessions were conducted by a Daytop graduate and two parent group leaders. Was it successful? We think so. Thirty-five children returned to attend all three sessions.

While the siblings were attending their meeting, their parents were also meeting as a group; the purpose here was to share ideas, thoughts and feelings. We encouraged the parents not to force their children to return to any one session; force would do more harm than good. The parents were given only general feedback since the emphasis was on strict confidentiality. Communication between parent and sibling was the biggest problem. Our eventual goal is to move this program into the ambulatory treatment centers.

Along with the changing times, the structure of the Family Association--the table of organization--has changed. The entire board is made up of 21 members--seven officers, seven chairpeople (one representative each from the seven outreach centers) and seven directors. In 1983, the entire committee structure was streamlined from 16 committees to 7 committees, with each of the committees under the aegis of a vice president.

By tightening up, we have strengthened the ability to govern, communicate and create new innovative structures. With the help of staff members, we support the agency to our fullest potential.

The challenge is always there! Since we are the recipients of those who came before us, we must be the guardians for those who come after us!

THE YOUNG WOMENS' GROUP

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Approximately five years ago Daytop Village's Family Association began separate support groups for wives, girlfriends and daughters of residents in TC treatment. It was an effort to provide these women with a forum that warranted separate attention. What began five years ago as one group for eight women has now grown to a program servicing forty women. The adoption of our Young Womens' Group Program into the mainstream of our treatment program heralds the advancement of these women to primary client status, as opposed to their initial position as secondary clients within the Family Association.

One of the many reasons for this development is the changing profile of the woman client that approaches us for help and our subsequent adjustments in clinical focus and goals in response to this movement.

Although 47% of the women have a substance abuse problem of their own--they have used drugs at some point in their lives and/or been involved with a substance abusing male--these women are not dysfunctional, but can be considered as being impaired by substance abuse or in some cases self-medicating. These women have welcomed or brought into the fold other young women who are working, single, married, divorced and many who have children and are seeking supportive treatment.

The hardship faced by all of these women is a serious social problem. We are servicing women who feel victimized, and this manifests itself in a variety of physical and emotional problems that include drug abuse. For these women their involvement with substance abuse, a substance abusing male, unhealthy and destructive relationships or behavior patterns is a reflection of or an escape from depression, fatigue, guilt, low self-esteem and lack of control.

The most common concern among the Young Womens' group program members, no matter what their background, is the fear, anger and stress associated with the belief that they lack the power to change and improve their circumstances. This is a women's program in every sense of the word. It is run by women, for women, and specifically addresses the concerns of women in today's society.

The majority of working women we encounter have been facing discriminatory barriers to employment or advancement, were steered into lower paying jobs, have been harassed or outnumbered in male domains, are rooted in dead-end jobs and educated from childhood to have lower expectations. This negative aspect of the woman's work situation is critical when they must support themselves and their children and, as a result, feel obligated to withstand mistreatment in order to survive.

Although we can view our current group members as basically different from the original group in relation to certain behaviors and historical aspects, the clinical issues remain essentially the same. The clinical profiles and problems presented are more similar than different.

The clinical issues addressed in these groups share a common denominator that crosses all backgrounds and lifestyles. They meet in these groups because they want and need help in coping with harsh economic and social realities and, in many cases, dysfunctional family systems or the additional complications of substance abuse.

As a result of my prior negative lifestyle, and graduation from the Daytop program, the women in the group are able to better identify with me as their group leader on various levels:

1) *As a woman.* There is an intimacy that is shared which develops the trust and encouragement that they need as group members.

2) *As a resident.* To provide them with a more accurate account of the therapeutic procedures during residency and the expectations upon completion.

3) *As a role model.* To support their own sense of accomplishment by providing the consistent example of a positive lifestyle.

During my term as a group leader in the Young Womens' group, I have seen women come into the group unemployed and go on to get jobs. We have seen women with little or no education go back to school. We have seen women who depended on unhealthy relationships go on to become self-sufficient. We have seen women who have had little ability to express their feelings openly share their innermost fears, articulate their emotional needs and develop a positive lifestyle.

The Young Womens' group has grown since its inception into a program that is servicing women in genuine need. The women have made dramatic and positive changes as a result of their group participation.

In summation, the Young Womens' Group is meeting the needs of its participants, and by developing this program Daytop is providing support not only to the resident with the drug abuse problem, but also to the family whose lives they so deeply affect.

I would like to thank Liz Gardner and Gina Ingbar for their assistance.

WHOLISTIC COUNSELING

Individual Family Relationships Substance Abuse Herbs

HERBAL TEA BLENDS INFORMATION SHEET

DETOX BREW	This blend contains comfrey root, mullein, spearmint, rose hips, orange peel and golden seal. Detox Brew has helped many people get off drugs the natural way. It is an aid to detoxification and is a tonic for the respiratory system, especially for colds.
RELAXO BREW	This blend contains valerian, spearmint and chamomile. Relaxo Brew is a natural herbal tranquilizer. It is an aid for relaxation and a tonic for the nervous system. Relaxo Brew also helps to settle the stomach.
ENERGY MINT	This blend contains peppermint, gotu kola, damiana, red clover, red raspberry leaf and eleuthero ginseng. Energy Mint is a mild herbal stimulant and energizer. It is a tasty substitute for coffee and contains no caffeine.
NUTRA TEA	This blend contains lemon grass, alfalfa, dandelion root, red clover, comfrey and orange peel. Nutra Tea is rich in vitamins and minerals with a delightful lemony taste. Alcoholics have used this blend to strengthen the liver.
BIOTIC BREW	This blend contains spearmint, dandelion root, Oregon grape root, red clover, chapparal, buckthorn and burdock. Biotic Brew is a potent blood purifier and cleanser. It brings oxygen to the tissues and helps to eliminate damaged cells from the system.
MOTHER'S TEA	This blend contains spearmint, red raspberry leaves and red clover. Mother's Tea is used in pregnancy to alleviate nausea and provides natural sources of iron.

Herbal tea blends are tasty alternative beverages with little potential for abuse. Herbs contain vitamins and minerals essential for good health. Herbs can serve as helpful aids but cannot substitute for appropriate medical or psychological treatment.

THE PARENTING PROGRAM AT WALDEN HOUSE

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Substance abuse is not an isolated problem. It occurs in the context of a family system and family systems occur in the context of society as a whole. There is substantial evidence of the importance of the family in the genesis, maintenance and alleviation of drug abuse (Stanton, Todd, et.al, 1982).

Addicts who are married are deeply involved in at least two intimate interpersonal systems, their marriage and their family of origin. A systems approach to drug use recognizes that the addict as "identified patient" represents a symptom of a dysfunctional family process.

When a member of a family uses alcohol or drugs, parenting suffers, and children are high risk for drug problems. Addict families exhibit a high frequency of multi-generational chemical dependency, experience a preponderance of death and separation themes, and sometimes sabotage treatment efforts. Family therapy has positive implications for prevention because more people are involved in treatment, family members who otherwise would not be accessible to treatment.

THE FAMILY CONCEPT AT WALDEN HOUSE

Walden House is a publicly supported non-profit residential chemical dependency treatment program in San Francisco, housing 135 residents from all walks of life, ethnic groups and socioeconomic backgrounds. It is an 18 month program consisting of a series of phases from Orientation through Re-entry to Aftercare, based on the therapeutic community (T.C.) model. The philosophy at Walden House emphasizes self-help, so that each client learns to take responsibility for his or her behavior. Clients are treated like human beings with potential for growth and change.

The therapeutic community is a highly structured and well-supervised program designed to deal with the behavioral and emotional issues of drug abusers. The staff at Walden House is a balanced mixture of professionals and ex-addict counselors working closely together. The therapeutic community operates on a "family" concept. Residents relate to one another as brothers and sisters. In the daily process of living, working and growing together, residents learn to trust others and develop positive feelings of self-esteem.

THE PARENTING PROGRAM

The Parenting Program at Walden House was designed to help residents who are parents to improve their family relationships and parenting skills. Each prospective participant in the Parenting Program undergoes an initial intake evaluation session to elicit relevant family background material, from which a treatment plan is developed. Usually the spouse and child are not residents at the same time as the "identified patient" and are living in the community.

These activities include: individual and family counseling by professional family therapists, group therapy, a series of educational workshops, a couple's group, psychological evaluations of children, home visits, multiple family groups and field trips. Family counseling may be done with the whole family, the client and his/her child, or the client and spouse. Occasionally the spouse is seen for individual sessions, depending upon the needs of the family as determined in the initial evaluation.

For newer residents, the educational workshops focus on nutrition, relaxation and concepts of child development as well as teaching specific positive parenting skills. Group discussion and experiential exercises are utilized to help clients understand the dynamics of the family and the roles they play in their own families. Nutritional information is provided to parents, particularly the effects of diet on children's behavior. Relaxation exercises derived from yoga and herbal teas conducive to relaxation are presented in these workshops (Nebelkopf, 1981).

The group therapy sessions focus on the emotional and psychological aspects of relationships and family life, with the goals of improving the client's self-awareness and relationships within his or her family.

In addition, supervised field trips and social activities for parents, their spouses and children are offered on a monthly basis. In the past, field trips have included picnics, baseball games, museums and amusement parks with the purposes of observing and giving feedback to parents as they actually relate to their children, as well as teaching them positive aspects of re-socialization as a family.

GOALS AND OBJECTIVES

The goals of the Walden House Parenting Program are as follows: to strengthen family relationships and improve the parenting skills of residents who are parents, to prevent drug abuse among the children of residents through individual/family counseling and education, and to help re-integrate families of residents through early intervention, education and counseling.

The specific objectives of the Parenting Program are as follows: residents will receive individual and/or family counseling on a weekly basis to improve family relationships and problem-solving skills, residents will attend a weekly Parenting Group to improve their communications skills and self-esteem as parents, residents and family members will participate in a field trip or social event each month to learn positive family re-socialization skills, residents will attend a weekly Parenting Educational Workshop to improve their parenting skills and learn relevant concepts of child development, and new residents will undergo an intake evaluation process each month to determine their participation in the Parenting Program.

All residents of Walden House are eligible to participate in the Parenting Program, including those clients who are in the Aftercare phase of treatment. The Parenting Program has been singularly successful in helping clients of Walden House to re-build the integrity of their families, particularly during the Pre-reentry phase of treatment.

GETTING FAMILIES INVOLVED

As part of the Family Services Program at Walden House is the Parents Association (The Walden Society), a support group for relatives and friends of residents. The Parents Association meets once a month for a community meeting and peer therapy and support group. It is an arena in which family members can deal with their own feelings and struggles within the family unit and learn how to provide positive support for the addict in treatment.

A mother of one of the residents at Walden House and member of the Parents Association feels that "As good as Walden House is, it seems to me that no matter how many positive internal changes take place in the residents, as soon as they return to spouses, friends, parents, etc., certain previous patterns get triggered unless the significant others are aided simultaneously."

Another member of the Parents Association, the wife of a resident, believes that "With a support group one can bear with the pressure of everyday life, while our loved ones are in Walden House. Group support is a time of giving as well as taking advice. With the group I feel part of the togetherness of a family, similar people sharing similar situations."

In addition, family therapy is provided for residents of Walden House and their own parents. The conditions and location of family counseling services are flexible, including short-term crisis work and long term therapy, communications workshops, positive parenting education and a variety of support groups for friends and relatives of drug abusers in treatment, at Walden House and in the community.

Field trips and various cultural, social and recreational activities are planned to provide positive interpersonal experiences for participating families. Through these activities peer support systems and self-help networks are being developed. Family members are being trained as peer counselors in the area of substance abuse.

A sliding fee scale has been developed so that families which can afford to pay for family therapy will help to support the program. The Parents Association has already undertaken a variety of successful fund-raising projects to help Walden House survive despite budget cuts.

CONCLUSION

The Parenting Program has been one of the most successful and consistent aspects of Walden House during the past four years. Since January 1982 there has been an average of 25 residents per month who have participated in the Parenting program. This is 25% of the entire population of Walden House. The Parenting Program has conducted 7 groups a month during the past two years with an average attendance of 10 residents per group. During this period there has been 17 field trips for residents and their families including trips to the aquarium, planetarium, museums, zoo, beach, and baseball games. Over 100 families have been helped in some way through Family Services at Walden House.

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ADDICTION, MARGINAL PATHOLOGY & SOCIETY

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Addiction: A Marginal Pathology

What does an addict say he cannot say? A therapist should place himself in the boundary between what is being said and what is not. Everything the addict is showing should be put into words. His actions, marked with impulsiveness, violence, cheating, even bribing, should be given a real meaning by the analyst. This work is not intended to answer what psychiatric nosography the addict belongs to. It will deal with the inflections of narcissism and language, both elements which help give human shape to the subject and which operate within a social and institutional framework.

Family and social conflicts provide, in turn, the setting for certain universal premises forming part of what we know as culture. The passage into culture will imply the conflicting observance of the law forbidding incest and all its consequences for the cultural constitution of man.

Thus, leaving aside the nosographic approach to addiction, as it would make us fall in an individualistic psychiatry, I feel it is important to study the subjectivity (1) of the addict, supported by the two big myths discovered by psychoanalysis as shapers of human nature: Narcissism and the Oedipus Complex. These act within a family and social reality (where characters and roles are developed) with a background of cultural laws that determine the passage from the natural individual to the cultural subject.

From this point of view addiction is a pathology of the family, of civilization and of subjectivity, interlocked at different levels.

Subjectivity is also seen within a framework. Think of the Kairological time of the Greeks that is a time for trial. Each stage of life poses new questions. We may or may not have the answers. A failure in the trial leads to a unique "seizure" of the subject. Consequently, an addict is also somebody who has been "seized" while being questioned during the critical stages of life: puberty, adolescence, parenthood, etc.

The Addict as Slave: What He Says Without Saying

Think about the etymology of the word addict: it comes from *adictum*, meaning without diction or something not said. At the same time it means slavery. The words themselves suggest the idea: those things not said (feelings suppressed or held back) imply a state of slavery. When something is not told, somebody becomes a slave of an object which, in turn, becomes his Master. It is only when someone expresses himself that he achieves some degree of independence from the object. However, while being subject to an object like a drug, the addict is trapped (2).

In a chain reaction pattern addiction reveals different stages of the critical pathology of civilization. At the same time there is a failure in the family to provide symbolic support for the conflicting passage from the natural individual to the cultural subject. In the end, we have the actual patient who comes for advice, living through a specific stage of life, generally adolescence) (3). Are we surprised when we find out that the addict expects an early death and has a contempt for any kind of standards, even those derived from bodily functions? So I wonder: What does the addict criticize about us, the consumers of this culture? What does the addict criticize about civilization?

In my previous works I presented serious pathology as a criticism of society, as a mockery of a sound way of living. Addiction is a true statement mocking culture and civilization. It is a criticism of the social mask from an absurd point of view. When speaking of addiction, the truth remains "clogged", fixed in an answer that does not lead to any further questions. Unfortunately, this social criticism costs the addict his life.

The Pure Culture of Death Instinct

S. Freud wrote in *The Ego and the Id*, "What prevails in the Superego is like a pure culture of death instinct. Very frequently does the Superego succeed in driving the Ego to death if this does not protect itself from its tyrant and looks for shelter in mania."

In the case of addiction, this culture shows itself in the double sense of the word: cult and cultivation of death. Ethnopsychiatry-- of analytical inspiration--as well as sociology, since the unequaled studies of E. Durkheim, insist on certain mortifying features of our civilization. Ethnopsychiatry shows us the existence of a technological-rational ideal with an ethic based upon performance and the supremacy of anonymity in human relations, so leading to depersonalization and bureaucracy. Furthermore, there is a need to standardize tastes and values through propaganda which submerges the subject even deeper into a world of images. It is from this point of view that our civilization can be described in certain aspects as technophrenic.

From another standpoint, sociology speaks about the crisis suffered by a competitive society in relation to social standards. Anomie and its social response--suicide--are examples of this. Addiction (4) is a slow suicide that undoubtedly responds to certain constant social factors. Durkheim says, "Modern societies can be defined by their social disintegration and by the weak bonds linking the individual to the group."

Later on he teaches us, "Suicide is an individual phenomenon that responds to social causes." To this we must add the destruction of ethical systems developed by mankind over the centuries in order to reach an ethics of performance. This ethic is based upon the imaginary identification of the subject from the machine, the former being "swallowed" by the latter. Consequently, in this age when rational ideals are prevailing and when the fruit of false religious myths seem to have vanished from the time when Compte thought he had buried them, primitive religious forms reappear: fetishism of objects and images. All civilizations gave significance to images and to the fetishistic worship of creation, but the present one places more emphasis on it.

Ecclesiastes tells us, "Man eventually ends up by worshiping the work of his own hands." Man appears in the present human framework as a mass linked with technique and with planning. These characteristics raise the matter of power--as well as its perversion--to a highest category (5).

Power not limited by ethics and subject only to its own effectiveness generates the possibility of destruction. Everything that does not fit in the power system is immediately put aside. The outsider is then a mockery of the power system which is "aware of itself but self-deceiving." S. Freud caught a glimpse of this when he wrote *Psychology of Masses* and *Analysis of the Ego* (1921) (6).

Narcissism as a Collective Formation

Since *Psychology of Masses* and *Analysis of the Ego*, narcissism is not considered to belong to classificatory pathologies, but it is related to collective formations, to co-actions. Narcissism is also a mass formation. Modern propaganda, employing as a technique the negative use of images, is an example of it. These mass formations reveal themselves as a power. From this standpoint, addiction is a social disease. A social demand is created from the social environment. An object should be brought into the consumption market. Overproduction is the master. New consumers are required; they too must be created (7). The addiction symptom is related with the structure of power as its counterpart. How is the death instinct culture spreading? By means of the negative dialectics that link the seducer with the seduced. Another symptom, from this standpoint, is drug trafficking.

We will be able to observe the peculiar submission that the patient is actively showing, when looking at the relationship between seducer and seduced. This evil period involves all the effects and the incidences S. Freud mentioned in *Psychology of Masses* and *Analysis of the Ego* when referring to the submission to the double, in the very field of hypnosis. Somebody or something takes the place of the master, while the other becomes the slave. This pattern occurs in the patient's family. If this situation is not changed, the actual death of the addict will occur.

An analyst today should criticize the pretended ideals of power based upon a deadly narcissism. In this way a new ethic will arise that will not only bring an adjustment of an individual regarding the environment.

Family and Addiction

Family can be regarded as an intermediate stage of a symbolic type. The different characters and roles provide the setting. The psychoanalytic studies of the family disclose a special distortion: wish is not adjusted, shaped or adapted by any object. The subject finds in the family a law for his wishes and a way of entering into culture, but he also fails to find satisfaction.

The laws conditioning the human being (e.g., laws forbidding incest) find their inflection point in family "mythology" (8): wishes of the parents, transgenerational influences, parent-child relationship. Three generations sharing the shaping of the subject, creating generational covenants or rivalry.

The symbolic covenant among generations guarantees the possibility of planning for the future. On the other hand, rivalry leads to early death or to different psychopathological probabilities.

Narcissism, previously described operating in certain social formations, is also found in the family, thus clouding the symbolic pattern of kinship the family should be representing.

At the same time, the family function has lost its symbolic "weight", when it seems to be more necessary, due to different social reasons (9). J. Lacan already showed the deterioration of family relationships, the fall of the father image, when he spoke about "the coming of wicked godmothers to the cradle of the neurotic to be." This analysis was based upon the family arising from the first and second industrial revolutions. The problem gets even worse with the so-called third industrial revolution.

Character and Role

The role of the father becomes a turning point between the family and extra-family aspects. This role operates through characters who show their influence according to their desire to represent that role. So we can observe that they may even hinder the mediation. They do not represent anything. They become lawmakers, lecturers, due to their intensive presence or absence. We are dealing with the narcissism of the father. From this point of view the father is immortal. There is no access to the stage of stage of the Dead Father, that is, dead to narcissistic identifications. We should recall Hegel's reflections in Jena: "Individuals are themselves death in process of becoming, but in the action of becoming dead, the action of becoming alive is implied."

The addict's family shows us a very special shortcoming as regarding the father as a representative of the law, because the actual father may be absent or intensively narcissistic -- dead, missing, humiliated, false, denigrated, a man consumed by the consumer culture. Or, on the contrary, he may be a marginal father, an outsider, resentful, violent, a robber who cannot obtain all the materialistic benefits that a consumer culture offers.

It is only in this interface of characters and roles (the symbolic patterns of kinship) that the interactions of the patient's family system may be analyzed. This symbolic pattern does not deny history. Quite the contrary, this is the basis of the generation gap, placing on the patient the burden of family background. The patient appears to be picked for family insanity; he is at the same time the scapegoat of the group and the sentry of his own pathology.

Family and Double Subjugation

In psychoanalysis family can be seen from two viewpoints: *famulus*, and *a femore*. The first, famulus, means groups of offspring, slaves and servants of a master. This meaning brings us closer to what a word imposes on us; conditions are ripe for double subjugation. In every family of seriously sick patients we can see that somebody is taking the place of some other, who becomes the Real Other of domination. The father, the mother, or the son will alternately play these roles, becoming lawmakers rather than representative witnesses. Different relationship modalities appear in these families: strong ties binding elements of different generations, weak ties binding elements of the same generation, inclinations to different forms of incest, sacrificing exogamy for the sake of endogamy.

Different stages of insanity are observed as a new form, "psychical inflection", suggested by Freud is taken up. The Dead Father who secures kinship for life does not exist. There is a father who is too alive bringing death forward.

The second viewpoint of family is *a femore* (10), in which family derives from femur, according to ancient writings defining genre and lineage. Lineage implies the long family ancestry and genre comes from generation: there are two of them, masculine and feminine. From this standpoint family follows the pattern of a living organism, defining the broad human areas, namely sexual difference, generational difference, and displacement from endogamy to exogamy.

Addict's Subjectivity

In my book, *Psychotherapeutic approach to Psychosis*, I describe the peculiar subjugation of the patient to his double. Relation with the symbolic other is substituted with the Real Other of domination (where the patient, or a significant relative alternately appears). A patient comes for advice. The father describes with surprise that his son has told him that he (the father) father was committing suicide. In fact the patient was right: his father was actually killing himself. But the patient--through his pathology--anticipated the death of the other by playing it himself.

In the mirror-couple (imaginary relationship where language as effect of trust is fixed or clogged) the patient can only be revealed by himself in his action. What role was this patient playing? He goes out to the streets telling everybody he is God and attacks policemen. Consequently he is arrested. The symbolic Great Other, corrupted by him and by the owner of the patient (his father) reappears in what cannot be symbolized. Father for real exposing him to castration in real. This in turn exposes him to a peculiar seizure as he becomes an outsider with a criminal record. Not "listening" to significant readings seizes him. M. Heidegger's analysis on "listening to" and "seizure" may help us understand this particular situation. He is caught on two fronts: out of the symbolic circuit and condemned as an outsider. Further psychiatric treatment reinforces his marginality as he pays psychiatrist's fees with marijuana--a patient bribing a partially legal representative, who plunged him deeper into marginality.

Psychiatric and psychoanalytical lectures have different forms of clogging pathology: how can one stop speaking about what cannot be said?

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(1) Subjectivity is opposed to individuality. Subject implies a primeval division and does not refer to "substractum" but to subjugation. Therefore I am speaking of a "subjected subject". Individual means "not divided". The human being is subjected to a pre-existent symbolic order which he does not know.
(2) In this analysis I shall use the triple record: symbolic, imaginary and real, following the concepts of J. Lacan.
(3) It is very interesting to analyse adolescence in our technocratic society and even the difference between it and that of more primitive and traditional societies. It seems that in our civilization adolescence is more conflictive, since the passage and initiation rites do not have the symbolic "weight" they used to have years ago. Besides, social problems such as the lack of creation of job opportunities in neighbor countries add new difficulties to the already hard times of living in society.
(4) In his celebrated thesis over suicide, E. Durkheim (1906) showed us the resulting from disorders caused by pathological consequences of work division and weakening of collective values. One of Durkheim's concerns was how a society could be kept alive and united with such a diversity of activities, work division and urbanization.

(5) We will see the importance this has for the present therapeutic community. Psychiatric development is essentially personalizing in front of an unpersonalizing reality.

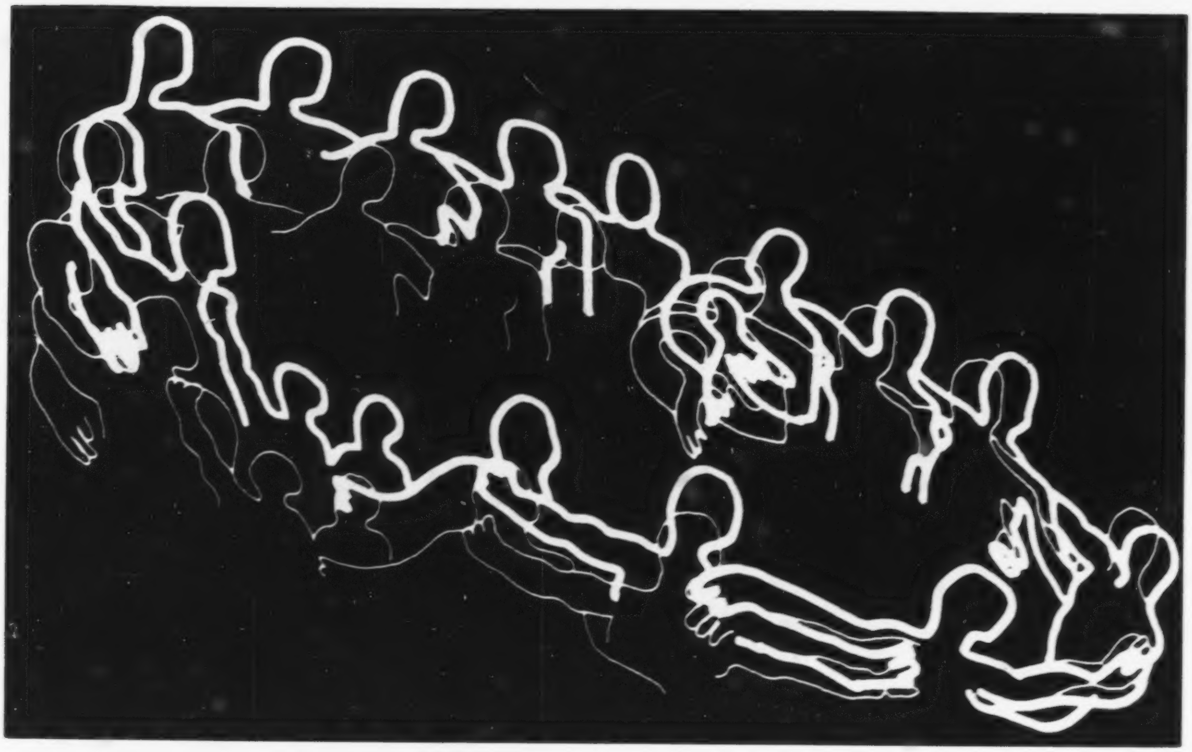
(6) Between the twenties and the thirties, interesting acts take place. M. Heidegger (1927) in Sein und Zeit gives us a warning over the anonymous world. In 1920 the National Socialist Party is formed.

(7) We only have to watch how the cocaine international price has dropped as a result of overproduction and the entrance of the Bolivian and Colombian markets in our country.

(8) J. Lacan in Myth and Truth in Psychoanalysis describes in detail the question of family mythology.

(9) We must study the passage from the traditional to the technotronic family, through the transitional family.

(10) San Isidoro de Sevilla: Etymologies B.A.C.



THE ADDICT AND HIS FAMILY IN THE TC

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In this presentation, I wil try to differentiate the functioning of the family of the drug abuser from the family of the psychiatric patient.

First I would like to clarify the context of Gradiva Therapeutic Community. It is urban, private and has been working for 13 years treating chemically dependent patients and psychiatric ones. Up to now 1,500 patients have been treated at the institution, together with the family group. Twenty percent of the residents are drug abusers. We have treated 300 drug abusers and their families. Drug abuse in my country deserves an explanation of its peculiar characteristics.

Eighty percent of the drug abusers, excluding alcoholics and tobacco smokers, are addicted to inhalants and prescription drugs which are available at any drugstore. The most commonly used ones are antitussives containing codeine and anorexigens that get people high. The other 20% is distributed among those addicted to marijuana, amphetamines or a combination of both. When an adolescent with these addictive characteristics enters the community, we certainly meet an expert in pharmacology. Cocaine abusers are growing due to the decrease of the international price of cocaine, but hard drugs such as heroin are quite unusual. We have only treated two heroin abusers.

The way in which psychiatric patients and their families enter a therapeutic community will differ according to the type of mental disease. Such is the case of schizophrenics, melancholics, suicidal clients, manic-depressives and their own families. This has been described widely by several authors, such as Harold Searles, Jay Haley, Nagy and Carl Whittaker, who have developed investigation on the way these mentally disordered families behave. For psychiatric patients the psychoanalytical and psychiatrical trend is very clear about the different therapies: individual, family, milieu and chemotherapy. Generally speaking these branches of investigation have not yet deeply studied the subject of the drug abuser and his family.

As far as I know, the culture of the drug abuser and his family culture are quite different from the culture of the previously described patients. This culture is neither psychiatric nor neurotic. Although we could observe that some chemically dependents and their families show psychotic or neurotic characteristics, I cannot go into considerations on this subject because this psycholopathologic description exceeds the length of time I was given for my presentation.

I will try to make up a brief summary of the development of impulsive sociopathic traits. An early muscular maturity that allows the invidivual to have a good handling of space is discordant with the capacity to integrate body and word-phrase representation; these people also have some difficulty in the ability to integrate space experiences with the succession of facts that have taken place in their lives. From a family point of view, we have a mother who lacks empathy and a father with difficulty in performing a protective role. I will call him an "ambiguous father." This is a different role than the absent father of the psychotic. The ambiguous father does not teach delayed gratification so that the addict never learns that he cannot get all he needs at the very moment, but has to wait. We will see how this situation is repeated in the model of behavior a drug abuser uses to enter the community.

Following the development of this sociopathy we can point that once it has settled in the personality, the patient will not be able to grasp the meaning of rules that will enable him to develop interpersonal therapeutic relationships. Sociopaths move on the basis of false assumptions. In relationships they learn: 1) to frustrate; 2) to transform the other one as a reflection of oneself; 3) to possess the other person and use him to promote intrigues; and 4) to praise the ego ideal of a person to influence the other person demagogically.

With time these impulses have become egosyntonic. It is not that they cannot control disrupting impulses, but that these have become so attached to their personality that their scale of values and their attitude toward what they send to others and what they receive from others has acquired an ethical dimension such that they despise people living in groups under common ethical laws. This constantly segragates them from the people who might gratify them. While they stick to unstable groups they suffer from loneliness and anxious depression.

Up to now, I have developed the family and the genetic-evolutive points of view. I would like to explore the social angle in the genesis of the chemically dependent character. Most of us, to a certain extent, are submerged in what is called consumer-oriented ethics. I would like to point out that our culture has created the need to consume. This has gone so far that although it seems a paradox, man is the one that is being consumed. No matter how; the important thing is to consume. Within this relatively modern ethic, I would add one more ingredient--the modern global village--where information is known instantaneously through the media. Through satellites we can can have the whole world at hand before our eyes and ears, with the different mixture of cultures and beliefs.

I would like to share these reflections with you. I think that psychoanalysis, through Freud, could decipher what the insensibility of the psychotic meant; that it is an attempt to get cured, an attempt to give an explanation. Similarly, chemical dependency could be construed as a strategy of coping in an alarming and ambiguous social environment based on the consumer oriented market.

Through my experience, the person that enters the therapeutic community will try to make us accept his transgressions to the rules and become his accomplices in certain actions that break the fundamental rules needed to live in a therapeutic community. The family influence on the patient shows through his manipulations to break the time limits he has been given set for treatment. In individual treatments, the therapist must pay attention to the impulse code that leads to action and implement an adequate non-technical language.

In order to protect the culture of the community, the members of the staff and the patients must have a flexible attitude, not a rigid one, of getting patients to confrom to the rules they will try to trangsress. The attitude of the community should be firm but understanding as this will diminish their self-destructiveness and will enable them to develop a sense of hope in life, to discover positive affective values, to become an agent of reflection who carries a message for our society, to understand that not everything is apocalyptical in life, to believe that life is worth being lived, that it should be lived, and that we must work hard for it.

In conclusion, I will define the therapeutic community as a counter culture for the chemically dependent patient. Sometimes, the therapeutic community is the only social support he has in the world, and it becomes very difficult to help him to resocialize. This is the case of the psychiatric patient, too. This faces us again with a social problem. The basic modification should point out to a change in social structure in which the human being should not be a mere object to be discarded.

THE MALE BATTERER

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The purpose of this study was to provide empirical psychological data on the male batterer in order to determine what variables are associated with wife abuse. Domestic violence has recently received considerable attention in the psychological literature (Walker, 1980), but researchers and service providers have focused on the battered woman (Star, 1978), paying little attention to the male batterer (Morgan, 1982); Rosenbaum & O'Leary, 1981). Granted that concentration on the immediate needs of the battered woman is appropriate, the ultimate reduction of abuse requires that we investigate the variables that contribute to a man's violent behavior toward his spouse. The man who physically batters a woman more than once during an intimate marital or marital-like relationship has been designated as a batterer.

Not all individuals who experience violence are batterers or battered women. The above definition differentiates violent spouses from others. It is a known fact that violence escalates in frequency and severity (Browne, 1983, Walker, 1980).

Domestic violence has been categorized into four distinct types as defined by the Family Violence Project (Sonkin & Durphy, 1982). The four types are: a) physical violence, b) sexual violence, c) destruction of property and pets, and d) psychological violence.

Physical violence refers to any physical action that forces another to do something against his or her will. Examples of physical violence include hitting, choking, pushing, grabbing, slapping, punching, hitting with weapons or objects, etc.

Sexual violence is defined as forcing another individual to have sexual intercourse or other sexual activities including rape, oral and anal sex, forces sex with animals, other people, or with objects. Thyfault (1980) studied a sample of 432 battered women and reported more than 50% of that population reported sexual abuse.

Destruction of property includes the breaking of any personal property, property of the spouse, including pets. Examples may vary from breaking dishes to killing the family dog. This type of violence adds to the psychological intimidation of family members.

> Psychological violence is defined as: name calling...it includes intense and continuous mental degradation; controlling someone's actions, behavior, etc., by threatening his/her well being; psychological manipulation that may be a form of brainwashing, or rigidly controlling someone's actions or behavior by psychological manipulation (Sonkin & Durphy, 1982, p. 12).

The increasing prevalence of domestic violence demonstrates the need for interventions. Legal, social, moral/ethical, and psychological approaches to the prevention, treatment, and rehabilitation of battered women and male batterers should increase. Research on the male batterer is almost nonexistent (Chomet-Petrovich, Zillman, & Sobocienski, 1980), yet treatment programs for these men have been implemented with minimal verification of the variable involved (Foreman & Fredrick, 1981; Sonkin & Durphy, 1982). Literature on domestic violence and male batterers has been descriptive in nature with little empirical data to substantiate the findings (Elbow, 1977; Shaniness, 1977). How is it possible to plan effective psychological interventions if variables associated with the male's violent behavior have not been verified? This study attempted to contribute to the literature by filling the gap between theory and the demand for services.

Domestic violence is a crime against women (Walker, 1980). Traditionally, crimes against women are a direct manifestation of an oppressive patriarchal ideology. Patriarchy implies that women and children need to be protected. Therefore, the need for protection allowed the patriarch to view his family members as "property." The notion of property led to the establishment of common law (Morgan, 1982), thereby cementing the belief of women as property of the patriarch. Morgan (1982) and Davidson (1978) reviewed the literature with regard to the establishment of "common law" and crimes against women, as it relates to domestic violence. The reader is referred to these sources for a rich elaboration on the subject.

In regard to the present study, it is necessary to understand how deeply embedded are Western society's beliefs of men as patriarchs and women as property. Pagelow (1981) postulated the highest prediction of women battering to be "traditional ideology." According to Pagelow, "traditional ideology is a range of internalized beliefs in the acceptance of the 'rightness' of the patriarch-hierarchical order of the social structure" (p. 40).

Presently, "traditional ideology" has its basis in early patriarchal notions and serves as the best predictor of domestic violence. Masculine traits that perpetuate notions of "strength," "authority," "protectors," etc., are adhered to by both male batterers and battered women alike (Pagelow, 1981). This study illustrates how male batterers learn authoritarian beliefs and how they are reinforced by the family and society.

The purpose of this study was to determine the variables associated with a man's violent behavior toward his spouse. The verification of the variables under investigation would allow the clinical community to focus on these variables that have a significant relationship to domestic violence. Intervention strategies could be better implemented at the primary, secondary, and tertiary levels of prevention. The assessment, treatment, and rehabilitation of violent men could then be directed toward those areas that have demonstrated a significant relationship to violence in the home.

Social Learning Theory

A theoretical social framework was used to explain the contingencies by which batterers learn and maintain their violent behavior.

The use of social learning principles allows the clinician to view the treatment of the batterer as a learning process with the following assumptions: a) There is hope for the batterer; b) since violence is a learned behavior, alternative behaviors can be learned; and c) the batterer is forced to take responsibility for his behavior rather than to attribute the blame to his "pathological nature." The primary focus of this study was limited to the male's contribution to the violence in the home. The woman's contribution to the violence was excluded, following the rationale that it is the male who is ultimately responsible for his own behavior. This is not to say, however, that women do not become violent. Recently, women have received attention for violence committed against their spouses (Brown & Wampold, 1983; Browne, 1983). This study was limited in its focus of the male as a protagonist of the violent episode.

The use of a multivariate statistical analysis, specifically the discriminant function techniques, provided the researcher with a method to analyze quantifiable data that may identify the significant psychological variables related to domestic violence.

Variables Associated with a Batterer's Behavior

The literature indicates that it may be possible to identify a "violence prone personality" (Walker, 1980). According to this hypothesis, characteristics of this personality include a history of family violence (i.e., witnessing and receiving violence in the childhood home), criminal record, lack of assertion, alcoholism, extreme traditional sex role expectations, conservative sexual attitudes, insecurity, tension, and possessiveness (Rosenbaum & O'Leary, 1981; Sonkin & Durphy, 1982; Walker, 1980).

The major source of this hypothesis stems from victims' reports or clinical observation (Elbow, 1977; Shaniness, 1977; Sonkin & Durphy, 1982; Walker, 1980). A paucity of empirical studies exists that has directly interviewed batterers and utilized standardized psychological measures to test this hypothesis.

The following variables were selected for investigation: a) history of family violence; b) traditional sex role expectations; c) personality characteristics of insecurity, tension, possessiveness, assertion; and d) conservative sexual attitudes.

The study was conducted in two phases: a structured interview was conducted individually with the subjects, and a battery of standardized psychological measures was administered.

Method

A matched group design was utilized in this study. Research subjects were matched on demographic variables with a clinical control group. The researcher was interested in identifying the discriminating variables associated with the male batterer's violent behavior. Thirty-eight identified male batterers were "matched" with 20 men in treatment at community mental health centers who were being treated for problems not related to domestic violence, psychosis, or neurological impairment. The extraneous demographic and treatment factors were controlled in order for the predictor variables to discriminate between the male batterers and members of the clinical control group.

The structured interview was facilitated by the use of Starr, Clark, Goertz, and O'Malai's (1977) Psychosocial Inventory that measured quality of life in childhood, adolescence, adulthood, history of violence, and patterns in significant relationships. The Cattell 16 Personality Factors (16 PF) (Cattell, Eber, & Tatsuoka, 1970) was used for the measurement of personality variables. Attitudes Toward Women (ATW) (Spence, Helmreich, & Stapp, 1972) measured sex role expectations. The Thorne Sex Inventory (SI) (Thorne, Haupt, & Allen, 1966) measured sexual attitudes.

Results

A stepwise discriminant function analysis (Wilks's lambda) was utilized to distinguish the best discriminating variable that would differentiate the two groups (Klecka, 1975).

The variables selected to discriminate between the batterer group (n = 38) and the control group (n = 20) were: a) history of violence; b) Cattell 16 PF scales--C-, easily affected by feelings; E+, authoritative; L+, suspicious; Q1-, conservative; Q4+, tense; c) conservative sex role attitudes as measured by the ATW; d) Thorne Sex Inventory (SI) subscales--B, sexual maladjustment and frustration; C, neurotic conflict associated with sex; D, sexual fixations and cathexes; F, loss of sex controls. The Cattell 16PF has 11 additional personality factors and the SI has five other scales that were also included in the analysis. The purpose of this was to see if the other measures were better predictors of differentiating between the two groups than the variable selected from the literature.

A discriminant function analysis was utilized to enter the most significant variables. A multiple regression was used to analyze the contribution of the most significant variables selected in the discriminant analyses.

Multiple Regression

A multiple regression analysis was conducted to assess the relationship among the selected prediction variables (SIA, SID, ATW, PFO, PFI, PFQ1, PFQ4) and the dependent variable subject group (Batterer: Control). The multiple regression is described in a stepwise fashion.

The groups appear to cluster on a dimension of "conservatism vs. liberalism" as defined by Thorne et al. (1966). The control group differs from the batterer group is scoring in a higher direction on SIA (.48), SID (.36), PFI (.21), and ATW (.23). The batterer group differed from the control group on the measures PFQ4 (-.21) and PFO (-.27).

Batterers appear to experience less sexual drive and interest (SIA) as well as less sexual fixations and cathexes (SID) in comparison to the control group. They seem to be more tense (PFQ4) and more insecure (PFO) than their clinical counterparts. PFQ4 and PFO are two of the six 16 PF dimensions that comprise the second order anxiety factor on the Cattell 16 PF (Krug, 1981).

The control group members appeared to compare themselves with Thorne et al.'s (1966) "liberal" end of the continuum of sexuality. They portrayed themselves as experiencing more sexual drive and interest (SIA) than the subject group. They scored considerably higher on fixations and cathexes (SID) than the batterer group; they scored slightly more liberal on their attitudes toward women (ATW) than the batterer group; and were more sensitive (PFI, r = .30 with ATW + .23 with group) than the batterer group.

In summary, the batterer group was: a) more tense than the control group, b) less sexually interested than the control group, and c) more insecure than the control group.

Discussion

This study had a twofold purpose. One was to provide empirical psychological data on the male batterer. Secondly, an attempt was made to differentiate male batterers from the general clinical population. The intent of the researcher was to provide information for the clinician that would help him or her become more effective in the assessment and treatment of male batterers.

A minority of clinicians has the necessary information to assess accurately when a batterer is in the consulting room. The aim of this research project has been to assist the clinician in this task.

It was established that batterers did not differ from the general clinical population with regard to violence in the family of origin. These results indicate that men who were abused as children or who observed spousal abuse do not necessarily become batterers. Also, the proportion of violence in the home experienced by both groups was equal. The implications are that a history of violence may be prevalent in the general clinical population, and that a large percentage of men (50%) who experience violence in their family of origin may not batter their spouse, but may manifest other psychological problems.

The groups differed on a measure of sex role attitudes. The scores on the ATW for both groups were significantly higher than in previous research (Rosenbaum & O'Leary, 1981). Rosenbaum and OP'Leary (1981) reported scores in the 30s and 40s for the battering group and the marital dysfunctional control group, respectively. The scores of the battering and control groups in this study were in the 50s, indicating a considerably more liberal view of women. A confounding effect of "social desirability," a trademark of all objective psychological measures, is purported to account for the higher scores in this study. In our modern society it is socially desirable for men to be more liberal in their attitudes toward women.

It was also established that the battering group was more conservative in their sexual attitudes than the control group. Thorne et al.'s (1966) research differentiated college students and drug addicts to be more liberal in their sexual attitudes than felons or sexual offenders. The control group in this study portrayed a similar profile. The battering group's profile on the SI was closer to the felons' than to the sexual offenders. Batterers portrayed lower sex drive and interest and denied conscious feelings of sexual deprivation, frustration, and problems with loss of sexual control.

Theoretical Implication

The two groups involved in this study did not differ statistically in regard to their history of family violence. Forty-eight percent of the battering group and 50% of the control group did come from violent homes. These subjects were questioned in a structured interview about what the quality of their life was prior to age 12. A majority of those abused as children felt that the discipline they received, no matter how severe, was deserved. However, opportunity for the acquisition of violent behaviors was equal for both groups. Social learning theory accounts for this phenomenon by the observation that "psychological function is a continuous reciprocal interaction of personal environmental determinants. Within this approach, symbolic, vicarious and self-regulatory processes assume a prominent role" (Bandura, 1977, p. 12).

Modeling may serve as a means to learn a variety of behaviors. However, this theoretical perspective lends support and credibility to the individual's ability to develop cognitions necessary for "self-regulatory capacities" (Bandura, 1977, p. 13). Inherent within this perspective is the notion that an individual can choose to behave in a variety of ways in response to an environmental antecedent. The men in this study demonstrated a variety of responses to conflict, stress, and frustration. Violence was only one response. Anxiety, depression, suicidal ideation, social isolation, drug/alcohol abuse, severe impairment in forming social and intimate relationships were other responses the men chose.

Growing up in an environment that stereotypes boys and girls dichotomously produces rigid sex role expectations. A second order effect of this phenomenon is that it makes boys anxious, insecure, and tense, particularly when they believe that they need to live up to an "idealized masculine image."

Summarizing the theoretical implication of the results of this study, it was found that individuals develop idiosyncratic cognitive processes to respond to similar environmental stimuli. Although the types of responses may have been maladaptive, a variety of different responses was evident.

Clinical Implications

The results in conjunction with the researcher's recent clinical experience suggest that batterers are psychologically "fragile." The heightened amount of insecurity, the intensity of their inner tension, and chronicity of their anxiety highlight the need for a strong, safe, therapeutic relationship. The tremendous need for "putting on a good front" may be recognized by the clinician as necessary for the psychological integrity of the batterer. However, the clinician need not be swayed or seduced by the false social competence of the batterer. The metaphor of "Jekyl and Hyde" may be a useful one to remember when assessing, in the consulting room, the potential for lethality of the individual at home.

With respect to the rigid traditional sex role expectations, therapeutic interventions could be structured to assist batterers in learning flexibility. The exploration of the individual's sexual relations and the underlying concerns appears to be necessary in psychotherapy. On a preventive note, the results of this study indicate a need for our society to promote non-traditional sex role expectations. The learning process in the home and the subsequent societal contingencies that promote non-aggressive means of conflict resolution are necessary if the amelioration of domestic violence will occur.

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CHAPTER 9

DRUG EDUCATION & PREVENTION

THE STATE OF THE ART OF DRUG PREVENTION PROGRAMS: A FIVE YEAR RETROSPECTIVE OF SCHOOL CURRICULA

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Fifteen years ago, the President of the United States stated that substance abuse education has the highest priority as a preventative measure and that information and training must be made available to all publicly educated children from kindergarten to grade twelve. Three years later in 1973, the National Commission on Marijuana and Drug Abuse declared a moratorium on all drug education programs in the school because they were in such of dismal state of disorganization (Chng, 1981). Drug abuse has been linked with the youth of our country and has been incorporated into the school system's domain with questionable results over the years. Moreover, the primary agent or delivery system for prevention programs has been teachers and school guidance counselors. Schaps et. al. (1981) notes that of the 127 programs he and his team reviewed, 61 programs or 48% showed that teachers were the primary deliverers of services. Clearly, there is the need for both educators and mental health practitioners to carefully review, analyze and question current learning environments, instructional activities, and curricula related to prevention education in order to obtain quality control. In this paper, curriculum is defined as the never ending invention of learning environments, a social process, and, as well, an educational endeavor. Learning environment is defined as systems of persons, things and activities organized to foster the developmental fulfillment and desired behavioral patterns of all learners. The total community then and the culture of which it is a part are the pre-existing learning environment (Morley, 1973).

The growing number of young elementary school youngsters now experimenting with drugs and alcohol (Johnstoon, 1984) only underscores the need to renew efforts to create appropriate drug education and prevention programs for all grades from preschool to grade twelve. An analysis of the basic issue surrounding this problem suggests that an assessment of current programs and trends in prevention education produced for school systems should be made. The school system does have contact with youngsters and consequently has the highest potential for the expansion of quality programs in conjunction with local substance agencies (Vissing, 1978). Substance abuse prevention education is seen an necessary for the schools, for students, teachers and administrators and auxiliary personnel and families.

Recent Gallop polls identified drug prevention education as a pressing educational problem. The data suggests that parents want schools to point out the dangers of drug abuse as well as smoking. Parents want schools to establish rules that will be a deterrent (Gallop, 1984). The public views substance abuse as an emerging moral and educational problem. If schools are going to take the initiative in developing quality programs, they must assess what has been done and then develop models of prevention education related to the needs of the youngsters.

The purpose of this paper then is three-fold: 1) to provide a framework for assessment of school curricula and school prevention education models; 2) to investigate a representative sampling of prototypes of recent school curricula produced within the last five years; 3) to begin to develop a state-of-the-art curriculum model predicated on educational and clinical concepts. Strata of school programs will be classified for review in four different ways: location, state or country, age and grade level, curriculum and instructional activities (teaching lessons), and format and learning objectives.

This article will address the issue of effectiveness of state- of-the-art prevention education from a comparative and evaluative perspective before considering the kinds of reforms and programs that are needed to alleviate current needs. There are many questions about the issues and difficulty in evaluating effective programs. In this paper, each program will be measured by two standards: first, the suitability or appropriateness of the educational material and second, the soundness of the clinical approach as well as the logical result of reduction of risk factors.

This investigation is developed in four parts wherein the first part considers the major types of program models and their salient characteristics. A second section considers the patterns and trends of each type of program. The third section examines the clinical and educational domains of the program. Finally, in the concluding section, we suggest some ways to create effective curricula models through interactive clinical and instructional techniques.

There has been a proliferation of substance abuse programs produced in the last five years, and it is impossible to examine each one. For the purpose of this review, representative programs across all grade levels from preschool to post secondary school from various parts of the country and abroad have been selected for analysis. For this purpose, programs have been selected on the basis of: 1) those which are representative of different types of program models; 2) those which are representative of different parts of our country; 3) those international programs that appear innovative; and 4) those which reflect accepted instructional practices both in the cognitive (information processing embedded in the subject matter) and affective (attitudes, feelings and values) domain.

Program Models and Their Characteristics

THE ADE PROGRAM (Chicago, Illinois) was developed for the public, parochial, and alternative elementary schools. A program which spanned both the affective and cognitive domain, as shown on Table 1, the activities include infusion of the alcohol and drug abuse education into the regular instructional program for children in grades kindergarten through eight. An important feature of this program was the level of teacher involvement and training. Teachers were trained by Alcohol and Drug Education counselors in the Schools Program (ADE) to serve as resources in their schools and were accepted into the program according to the following criteria: 1) teach at an elementary school located within one of the designated Neighborhood Strategy Areas; 2) complete and submit an application form; 3) submit a signed statement from their principals expressing support and recommendation; 4) participate with their principals in an orientation session conducted by ADE staff. Community interaction was assured through communication network with the school. Parents and community ç participated in workshops with school personnel to keep informed of the progress of all participants and to increase the awareness of the activities (Sherman, Lojkutz and Steckiewics, 1980).

The program included implementation and program development and therefore, emphasis was placed on the problems which were encountered prior to and during the implementation of program activities.

THE ALPHA CENTER (Orlando, Florida) was developed by The Door of Central Florida, Inc.This program is an eclectic blend of many different approaches to academic instruction and child development (Resnik, 1980). A significant feature of this program is its use of behavior modification techniques to create a change not just in the children who attend the school, but in these childrens' families and in public schools in the community as well, as shown in Table 2. The Alpha Center made the initial contacts with public schools in low income communities. The center targeted three schools who work with in three eleven-week cycles per year. Twenty students in grades three through six who were identified as experiencing social adjustment and family problems were selected for participation by the school's administrators and teachers. Identified students, with the permission of their families, attended classes at the Alpha Center for three school days each week. On the alternate two days, students attended regular classes in their home schools.

In tandem with the youngster's participation wa a parental component which provided for one session a week of family counseling and/or parent sessions as shown in Table 1. The teachers received three full days of in-service training during each eleven-week cycle. Training techniques included: transactional analysis, reality therapy and other forms of positive reinforcement and behavior management. The Center's curriculum stressed instruction in basic skills, the arts, music, and physical education. Additionally, the Center developed a course in decision making about medicines and drugs. Evaluation was achieved through observation by the Alpha Center staff of the students in their home schools. The staff provided the teachers with feedback on student interaction with faculty and classmates. Preliminary findings indicated that three months at the Alpha Center resulted in twice the normal growth in basic skills and significantly improved social behavior (Resnick, 1980).

COME AROUND THE FIRE CLOSER (NIDA) is a program in the affective and cognitive domain. This program involves a bibliotherapy approach by using tribal stories, myths and legends as tools for preventing the abuse of drugs among Native Americans. This resource provides a collection of stories and legends. As shown on Table 1, this type of prevention focuses on the person (NIDA, 1980). People such as teachers, counselors and librarians working in the field of drug prevention can use these stories by telling, dramatizing, collecting, recording and illustrating them.

The overall goals of this program are to build personal strengths, to provide ways of coping with problems, and to clarify values. The most important part of this program is that it provides alternatives to drugs. These alternatives are activities which satisfy the same needs that drugs do but in ways which provide lasting satisfaction. This approach is more of a tool than a program, and therefore has never really been evaluated. More importantly, the stories can be used with any group of any age, depending on the resources of the group.

HASHISH AND MARIJUANA (Haifa University, Israel) is a preventative program in drug education which equally emphasizes the cognitive and the affective domain. This is an interdisciplinary drug education curricular program for high schools specifically designed for the natural sciences in the eleventh and twelfth grades. The authors (Zoller and Weiss, 1981, p. 39) explain their guided curricular program in the following way:

> The contemporary "fourth generation" of preventative programs in drug education is typified by the following main characteristics: 1) inter-disciplinary in approach; 2) a deliberate effort to simultaneously integrate the cognitive-informational and the affective-behavioral domains; 3) fostering of the "value judgment" component within the development of the involved students' decision- making capacity -- to be applied under a variety of life situations; an emphasis on the affective, behavioral, personal, and societal components of learning.

The curriculum was included within the framework of the science teaching and traditional general chemistry program in the upper level of high schools. Preliminary field test evaluation generated in a pilot study revealed that there appeared to be a decline in positive feelings of the involved towards the drug issue. The curriculum appeared to have been accepted favorably by both teachers and students wherein the latter gained much knowledge and understanding with respect to the various aspects involved in the drug issue. The program did not cause any increase in hashish smoking among the target population.

HEALTH INSTRUCTION FRAMEWORK (California Public Schools) is a program which embraces both the cognitive and affective domain and is a comprehensive approach to Health Education. This is a kindergarten through grade twelve curriculum and is therefore offered to all students in the state of California as shown in Table 2. Unique aspects of this school-based prevention programming was that it is: 1) governed by and/or located primarily in an educational setting and is accountable to a local educational agency; 2) operated in accordance with Education Code provisions for drug and alcohol abuse prevention and education. The curriculum emphasizes attitudes and decision making as well as information. It was developed through cooperative planning of a school site council, school personnel, parents, and community representatives. This program offered a strong in-service training component on a continuing basis rather than a stop gap basis. A significant part of the in-service component is the team approach.

Teams included administrators and parents as well as other school staff. Relevant activities and cooperative relationships and linkage in this prevention program was established between personnel in community agencies and a citizens' advisory committee. The program design incorporates formative or on-going evaluation as a means of accountability and as a vehicle for assessing students' needs dispositions.

LIFE SKILLS FOR MENTAL HEALTH (Georgia) is a program exclusively in the affective domain. This approach focuses on intra- and inter-personal skills that help in handling stress and decision. The major goal of the program was to assist participants in taking responsibility for their lives without recourse to drugs and alcohol. Activity guides were prepared by the Prevention Unit within the Division of Mental Health/Mental Retardation, Georgia Department of Human Resources (DHR) in a collaborative effort with the State Department of Education and community mental health centers. In 1980, three quarters of the state of Georgia was given over to the aforementioned curriculum. A significant part of this curricula approach is that it car be adapted for other adult organizational leaders such as Sunday school teachers and scout leaders.

The program includes four activities similar in format, but geared to specific age ranges as shown in Table 1. The guides are organized into three sections which correspond to the three major objectives as shown in Table 2. The program was evaluated on student and teacher outcome. Both a product and process evaluation were employed. The following conclusions were drawn from the evaluation: 1) the Life Skills program was effective in reducing disruptive behavior and increasing positive teacher and student affective behaviors; 2) minimal support for effects of the Life Skills program in increasing student self concept, interpersonal skills, classroom climate, or attitudes toward school was found in this study; 3) no evidence of support for effects of the Life Skills program in reducing drug or alcohol use was found in the study; and 4) previous findings on frequency of drug use and in differences between the sexes on drug attitudes and drug use were replicated.

NAPA PROJECT (California) is a prevention program in affective education. This program focused on teaching intra- and inter-personal competences to children as well as responding to their social and cognitive needs. This curriculum teaches self-esteem, interpersonal skill development, decision making and problem solving. An important element in this approach is an in-service training program for teachers. Teachers use different strategies to attain their goals, i.e., magic circle, jigsaw, cross age tutoring and operating a school store as. Those educators participating in this project were trained in the previously cited in-service strategies during nine to twelve weekly two-hour workshops. In addition, trainers observed the teachers' use and application of the in-service skills. In-service courses utilized a bevy of instructional strategies such as lectures, discussions, readings, gaming simulations and practice exercises. As an incentive for participation, teachers who completed the training received a stipend and graduate credit.

NEW YORK STATE CURRICULUM (New York) is a substance abuse education program which is subsumed in the Health Education curricula. Substance abuse prevention is taught as part of Health instruction. These curriculum guides were developed as a direct result of the Board of Regents Action Plan to reduce alcohol and drug abuse in the schools in response to the problems of substance abuse. This course of study combines elements in the cognitive and affective domain. Curriculum guides from kindergarten to grade twelve are available upon request from the State Education Department. These learning materials are essentially resource guides for planning and are offered to individual teachers and school districts. An individual curriculum guide is available for each grade level.

OMBUDSMAN PROGRAM (North Carolina) is a primary prevention program rooted in the affective domain. It focuses on activities which include decision making, self awareness and helping others. The student participants included a group of individuals not yet using drugs. The program targets elementary and high school students. School activities included learning about values, communication skills, decision making, and helping relationships as shown in Table 1 (Kim, 1981). This three phase program begins first with a series of self awareness exercises; second, group skills to develop decision making, communication and problem solving; and third, ombudsman (the Swedish concept of helping person). In this phase, the students applied the knowledge and skills gained in the earlier phases by planning and carrying out a community project. This phase appears to be crucial because students were able to re-evaluate their role and their relationships in the school, family and community.

The structure of this program provided for two 50 minute sessions per week for approximately fourteen weeks per semester as shown in Table 1. An evaluation and impact study was done to pinpoint the effectiveness of the program's primary objective. It appears that the program proved more effective among students whose regular classroom teachers had OMBUDSMAN training than those whose teachers did not have training. The Ombudsman program proved more effective among elementary youngsters rather than among junior high students (Kim, 1981).

PERSON EDUCATION DEVELOPMENTAL EDUCATION (PEDE) is a Minnesota junior and senior high school program which focuses exclusively on the affective domain. PEDE's primary goal is to create a process for involving teachers, administrators, students, and parents in dialogue in order to ameliorate students' behavior, family relationships, and school climate (Resnik, 1980). The participants included low and middle income students from public and parochial schools. Programs varied from school to school and therefore varied according to the needs of the school community. A PEDE corps was created which consisted of school administrators, teachers, students and parents from each school. This core group then became the prime mover of constructive change. A primary emphasis of this program was the family systems approach energized by peer counselors. In addition, teacher workshops stressed communication skills as The PEDE group stressed improving communication between students and teachers. This program was described as still evolving and therefore not yet firmly established.

SAYING NO (NIDA) is a resource guide for teachers of middle school of junior high school, ages 12 - 14. Suggested activities are designed to be infused in every subject discipline. Skills are flexible so that they can be integrated on almost every developmental level of youngsters in that age group The objective is to increase student awareness of the personal, social and historical factors relating to the lives and work of people influential in the development of the United States and of other countries. Teachers are told to highlight the lives of individuals whose achievements influenced history and technology in spite of pressures from their family, friends, or community to abandon their work. Examples of both men and women from various ethnic backgrounds are given. Student activities include oral reports, short plays and panel presentations, art work or a written essay which depicts the student's encounter with a similar pressure.

This guide is a tool, and therefore a supplementary means of aiding teachers to think about drug prevention in the classroom. An interesting segment of the guide is a bibliography of other resources and general information related to drugs and their effects.

SPANISH LANGUAGE DRUG PROGRAM (Arizona) is sponsored by Partners of the Americas, Washington, D.C. and Arizona State University. This program in the affective domain utilizes traditional value gaming strategies. It was piloted in a juvenile residence for high school boys in Mexico. The goal of this program is for the male clients to create a system of self analysis. In the next step the boys would relate the valuing to non-medical and substance abuse. A student activity book with cross cultural relevance was developed for this Spanish language program. A teaching manual, also in Spanish, was developed to be used in conjunction with the student values clarification activity booklet to train counselors, teachers, public health educators and para-professionals. A useability evaluation indicated that Spanish speaking agencies could utilize the student guide and instructor's manual as tools for drug education for their own staff conducting the program (Toohey, Valenzuela, Dezelelsky, 1981).

TEEN INVOLVEMENT (Arizona) is a program in the affective domain. The primary objective of this program is prevention by helping youth make rational decisions (Conroy and Brayer, 1983). The program has been replicated throughout the nation and overseas. This system involves establishing a cadre of teen advisors who remain with the school and class answering questions regarding substance abuse. The relationship is built on respect and mutual trust, i.e., if the teen advisor does not know the answer he/she freely admits it. In a sense, this program is very much like a mentor program in that it involves high school students in participating 5th, 6th and 7th grade classrooms. The high school student helps the younger student negotiate the school scene.

Teens are recruited on a volunteer basis and as more volunteers are needed they are recommended by current volunteers. Criteria for selection include interest, willingness, and the ability to communicate positively with others. Training involved attendance in seminars which include various do's and don'ts, and some of the techniques and strategies are rehearsed prior to class visits. The classroom teacher remains an important link in this program. The teacher provides feedback for the teen advisor and aids the teen in articulating the goals of the program.

THE DOOR - A CENTER OF ALTERNATIVES (New York) uses a multi-service learning laboratory concept. This program embodies an open classroom approach for youths 12 to 21. The Center focuses on basic skill building and therefore is a program essentially in the cognitive domain. However, affective orientation is a significant component in any therapeutic approach. The learning laboratory approach includes a variety of learning materials designed to maximize learning styles. The learning activities are organized into five general areas ranging from individualized basic skills workshops to community meetings and special projection topics of particular interest to adolescents. The areas of study include Spanish, consumer advocacy, mathematics and reading. Educators make efforts to find and use materials meaningful to the lives of the inner city youngsters they serve. Materials such as subway maps and application forms are used. Experiences drawn directly from the everyday activities of the clients become part of the instructional activity.

Teachers are assigned to participants as both teachers and primary counselors and advisors. Teacher training focuses upon the psychological dynamics of adolescents, drug abuse, record keeping, communications and needs assessment (Pedrick and Greene, 1980).

The approach appeared to be effective in identifying underlying factors involved in drug abuse and educational problems. Six evaluation modalities were employed, i.e., client maintained journals, end-of-cycle evaluations and diagnostic educational indices. Attitudes, habits, interpersonal skills, values and academic skills were all considered relevant components of the educational process.

Trends Within the Last Five Years

There is a plethora of substance abuse programs whose content focus may be feelings, attitudes, and values training as well as programs which combine materials and curricula in basic skills and interpersonal relations. Trends also indicate a growing number of at risk young elementary school youngsters, yet programs appear to target middle, junior and senior high students. Shaps et al (1981) report that 56% of the programs they reviewed were designed for 14 to 18 year olds and 40% were designed for 12 to 13 year olds. Programs designed for 6 to 8 year olds comprised 6% of the study.

Many states do have comprehensive through grade twelve curriculum guides, i.e. New York. However, drug education is subsumed in different subject disciplines, i.e. Health education, but in general, little attention is given to curriculum development for very young children. Yet a recent study by Tennant (1979) suggests that preschool children may be a suitable target population for substance abuse education since awareness of these behaviors appeared to be very çhigh in the group of children studied.

Educators should now ponder the efficacy of drug education beginning at kindergarten through grade three (Cohen, 1977). A major goal of this level education could be to help youngsters develop positive attitudes toward self and society, develop positive attitudes toward self and society, develop positive values, self images and become more responsible for their own health and welfare. A possible approach was suggested by the 98th Congress Proceedings subcommittee on substance abuse education chaired by Senator Paula Hawkins. The committee discussed the possibility of the use of animated films for reaching preschool children.

Programs developed within the last five years appear to have moved away from the earlier tactics Haes and Schuurman (1975) describe as the mild horror approach, the fact approach, the individual adjustment approach to multi-faceted interactive program models. But program design in the last five years may reflect a potpouri of attempts to solve a yet to be defined problem often extended by the lack of communication between educators and clinicians in the field.

Many program developers have begun to recognize the importance of careful selection of teachers and in-service training of those teachers in psycho-social forms of reinforcement and behavior management. Another significant factor related to programs in this decade of the 80's is the emphasis on teaching decision-making and life coping skills. The ongoing motif of program development appears to be the use of teenage role models as speakers, advisors or mentors, although peers appear to be used rather infrequently. Additionally, some educators report that they are now beginning to recognize the importance of using "the teachable moment" (Silverstein and Derivan, 1984) as a spontaneous opportunity for promotion of positive alternatives to substance abuse. That is to say, teachers now use that opportunity which arises serendipitously during the lesson to achieve the previously cited goals.

Finally, many institutions realize the rich potential of literature as a vehicle for discussion and clarifying values. This is evidenced by the creation of resource guides utilizing fairy tales and legends as a bridge to understanding and a mechanism for role projection and identification.

In summary, programs recently developed within the last five years seem to focus on the affective domain (attitudes, feelings and values) and target middle school and junior and senior high populations. The programs are interactive models and in some cases utilize personnel other than teachers, but on the whole, most programs today are housed in schools or school district officer or even a few in universities. Some teachers participate as part of a "community team." These teachers are frequently observed in the classroom by students, peers, parents, and mental health counselors. Finally, educational materials have been developed as part of organizational programs for "community team" members such as agency counselors, parents, cross-age peer counselor, Sunday school teachers, and public health counselors. The implication may be that a more colleagial relationship is coming to the fore.

A State of the Art Model

A model for the decade of 80's must incorporate the overriding principles of prevention. Tantamount to this model is a distinction between and among primary, secondary and tertiary prevention. Swisher (1979) notes that primary prevention is a program timely before abuse. The activities include education, information, alternatives and personal and social growth. Secondary prevention is timed during the early stages of abuse and its activities include crises intervention, early diagnosis, crises monitoring and referral. Tertiary prevention is a program timely during later states of abuse and the activities include treatment, institutionalization, detoxification. The criteria for admission to the previously cited prevention models remains nebulous and vague. Surely, establishing those differences is a generic principle of program design.

Schools are the primary societal institution serving young people, second only to the family. Society also assumes the position that socializing and humanizing tasks fall within the review of the school. They argue that children spend most of their time in school and that school is the logical agent to negotiate the increasingly complex socializing process of children. But schools are not the sole institution serving today's youth. Therefore, a state of the art prevention model must first reflect in its strategies and design a collaborative effort of school personnel (board, administration, teachers, counselor) student/youth representatives, medical health personnel, law enforcement, representatives from voluntary organizations, local clergy, substance abuse workers and parents (Cohen, 1985). To this end, prevention must be viewed as an all-encompassing process of development touching every aspect of a youngster's life.

This concept is predicated on the need for a close relationship between schools, families and the greater community. Biber (1961) notes that the challenge is to maximize the circular growth process toward greater learning power and inner strength in the interest of primary prevention. The task must be one of shared concern. Secondly, a state of the art model should include a curricula which is comprehensive in scope starting at the kindergarten level and extending through grade twelve in a spiral fashion speaking to the problem at each of the youngster's developmental stages and thus avoiding the one shot approach. Curricula should reflect the needs and cultural relevance of the community and be produced in other languages if necessary. Attention should be given to special populations with special strategies tailored to the needs of a specific group, i.e. high rise, abstainers, fencesitters and drug abusers, thus assuring students participation in the appropriate prevention program.

Consideration should be given to distraught persons, the curious, the defiant as well as to the development of materials for different groups such as the handicapped. Learning activities should reflect cognitive (knowledge) and attitude behavior (affective elements) undergirded by developmental tasks for students which attend to the different stages of a child's development. These tasks should be appropriate and necessary for acceptable functioning and subsequent development of the child.

A third element in this model should be a vigorous in-service and pre-service program for teachers and future teachers who express interest in such a project. Teacher members should not be arbitrarily assigned to substance abuse prevention programs. Only people who have expressed concern and interest in and commitment in this area of education should be trained.

Finally, a strong evaluation component is a necessary element in this model. Formative or on-going evaluation as well as summative evaluation at the conclusion of the program year in needed to reshape goals and establish accountability (Iverson, 1980). Process as well as program outcome evaluation is necessary to evaluate the processing of the program.

Conclusions

The results of this study, together with previously cited studies show that there is no magic answer to the design of an effective prevention program and that programs developed within the last five years are more comprehensive and sometimes involve other team members outside of the school. But educators should pay close attention to the psycho-social dynamics and the social norms of the participants. Several desirable attributes emerge for future program design: 1) a multi-faceted program design; 2) interactive partnership with the community; 3) strong commitment from the educational leadership and the teachers; 5) peer involvement as mentors and counselors; 6) a continuous kindergarten through grade twelve curriculum embracing knowledge and attitudes tailored to the needs of special populations; and 7) a formative and summative evaluation design which is harmonious with the learning objectives of the program.

In conclusion, what is needed is commitment and the concerted efforts of very many people functioning in a colleagial manner to work for the common goal. Efforts should involve individuals from different target groups. The future of substance abuse prevention education will be greatly affected by the degree to which program planners work in close collaboration in research, program design, c development and evaluation. An integrated coehesive approach to support prevention education may be the key to effective school prevention projects.

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THERAPEUTIC COMMUNITIES: EDUCATION FOR WHOLENESS

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There is an old Hasidic story of a rabbi who had a conversation with the Lord about Heaven and Hell:

> I will show you Hell, said the Lord, and led the Rabbi into a room in the middle of which was a very big, round table. The people sitting at it were famished and desperate. In the middle of the table there was a large pot of stew, enough and more for everyone. The smell of the stew was delicious and made the Rabbi's mouth water. The people around the table were holding spoons with long handles. Each one found that it was just possible to reach the pot to take a spoonful of the stew, but because the handle of his spoon was longer than a man's arm, he could not get the food back into his mouth. The Rabbi saw that their suffering was terrible. "Now I will show you Heaven," said the Lord, and they went into another room, exactly the same as the first. There was the same kind of big, round table and the same size pot of stew. The people, as before, were equipped with the long-handled spoons, but here they were well nourished and plump, laughing and talking. At first, the Rabbi could not understand. "It is simple, but it requires a certain skill," said the Lord. "You see, they have learned to feed each other."

Two groups of people were given the same set of circumstances. The first assemblage of persons suffered terribly--they were hungry, drab, dispirited, unrelated and independent of each other. The second group had a level of awareness that made it possible for them to realize when their individual resources were not adequate. By helping each other, not only could they satisfy their needs, they could do so with joy.

Both groups were faced with a problem situation but the two groups behaved in ways that reflect two different learning theories. The first seems to have learned that growth toward maturity is to become independent; the second, that growth toward maturity or wholeness is to acknowledge and to act upon our interdependence.

We might conclude from this Hasidic story that Heaven has a resident population of family members who have learned how to live together lovingly, creatively and inter-dependently in a community that is therapeutic, where each member can "take root and grow," alive to self and others, consistent with the objective of a therapeutic community, which is to grow toward integration or wholeness.

Therapeutic communities, historically, have regarded themselves as treatment centers for drug addicts. However, they can also be seen as educational institutions.

Congruent with the perception of therapeutic communities as educational institutions, the emphasis in this paper has been shifted from therapeutic communities as treatment centers to therapeutic communities as learning centers. Treatment suggests a medical model, whereas learning centers suggests an educational model. Treatment implies arresting a process of pathology; learning implies promoting a process of personal growth.

The purpose of this paper is to examine the educational philosophy of therapeutic communities and to relate that philosophy to the education of whole persons. Education in therapeutic communities begins with the premise that "the whole person is in need of healing;" or in more academic language, the whole person is in need of being educated. This holistic approach to education is not the norm of the wider American culture in which home, school and church try to maintain distinct and separate functions.

Therapeutic communities can be regarded as innovative learning laboratories which describe themselves as "a new direction in helping persons to help themselves." In that education is highly regarded throughout the world as a way to help oneself, an educational program which has demonstrated that it can make a difference is worth examining.

It is customary in education to set goals, experiment with procedures to implement the stated goals, and to evaluate the results. The primary goal of a therapeutic community, as stated by American TCs, is "to foster personal growth." The recommended procedure for accomplishing the goal is to "live in a community of concerned persons who are working together to help themselves and each other." The desired result is changed persons who have altered their attitudes and behaviors and have opted for a different life style. The criteria for evaluating the educational objectives are reality-based: drug free, crime-free, employed and/or in school.

The educational objective of personal growth as evidenced by changed attitudes, behaviors, and lifestyle is comprehensive, ambitious, and difficult to attain. Therapeutic communities demand growth, facilitate growth, and accomplish growth, particularly for those persons who finish and become graduates of the community. Let us examine the learning environments of therapeutic communities.

First, the classroom climate, both clinically and academically, is that of a family. The TC atmosphere resembles the classroom in an earlier era in American education when grades one through eight were grouped together and much of the teaching was done by the older pupils. Simultaneous with the teaching of content was the teaching of two attitudes: responsibility and involvement. Those who knew more helped those who knew less. Also, those doing the teaching found that the best way to reinforce one's own learning was to teach it, that the best way to try to help oneself was to help others. Therapeutic communities are educational institutions with a resident population who teach and learn in an interdependent educational process in a family setting.

Many American TCs have an academic component. Those members of the family who have not graduated from high school have acquired equivalent qualifications by the time they have been graduated from the TC. Daytop Village goes beyond the high school level to the college level with an educational experiment, begun in 1979, known as the Miniversity. A Miniversity group of 15 to 20, a small family which is part of a larger family, has tremendous potential for people helping people to help themselves.

In December of 1984, two persons in a particular course at the Miniversity had not taken the final examination. The Miniversity group called a departmental meeting. The leader of the group said during the meeting, "If one of us fails, all of us fail." After considerable probing and discussion, the two persons decided to study and to take the examination. Before they came to their decision, various members of the group had offered to help them with anything they did not understand as they were studying. One of the two who was to receive help offered his help to those studying for an examination in another course which he felt he understood.

In contrast to this mutually caring family environment for learning is the academic world outside the TC where helping a classmate is jeopardizing one's own best interests. This brings us to the second characteristic of the educational world of TCs: education is facilitative rather than competitive. During the summer of 1980, Allen Gewirtz, a mathematics professor from Brooklyn College, advised the math class at the Miniversity: "I am here only once a week. In the meantime help each other. Try to make certain, though, that the person you are trying to help understands." The academic program enhances the clinical emphasis of persons helping persons to help themselves. The facilitative group learning in the academic setting within therapeutic communities is startlingly different from the individualistic, competitive nature of learning in the educational world outside therapeutic communities. To transplant the idea from group therapy that "We alone can do it but we can't do it alone," to an academic classroom is novel, indeed!

A third essential ingredient of education in a TC is the awareness of the importance of being a whole person during the educational process. Education in a TC is life; it is not time out to prepare for life. The Miniversity student is first of all a member of the family with responsibilities related to family membership. When first observed in 1980, the Miniversity students had a separateness from the rest of the family; they seemed to have been excused from a considerable number of family activities. In the summer of 1981 the pendulum seemed to have swung in the opposite direction and the Miniversity students were coming out of encounter groups at 9:30 p.m. with a statistics test yet to be taken. In response to an inquiry in December, 1984, the Miniversity group, when asked about family responsibilities and time to study, indicated they were satisfied with the balance that had been worked out.

The demand to be a whole person, alive to self and others while being educated, suggests a fourth dimension of education in therapeutic communities: a balance between being and becoming. There ç is an uneasiness among some academicians that so much energy is directed toward what one is being educated to become that little time or energy is invested in what one is in the present, that being is sacrificed to becoming. The sacrifice of the present to the future is particularly disturbing if we feel that much of education is future-oriented for a future that is unpredictable. There is a need for education to be meaningful and relevant in the present.

The demand to live well in the here-and-now, to be responsible and involved, is a constant in therapeutic communities that gives relevance to the educational process. Training for responsibility and involvement is not in danger of being outdated by future events. Such training reflects a view of the mind less as "a storehouse to be filled" than as "an instrument to be used."

Closely related to being a whole person, with attention being directed to being as well as to becoming, is a fifth aspect of the TC culture: the emphasis on personhood. In a book, The Identity Society, William

Glasser (known to many as the author of Reality Therapy and Schools Without Failure) discriminates between a goal-oriented and a role-oriented society; he indicates the difference is critical. Although therapeutic communities state their goals, they would seem to be more growth-oriented than goal-oriented. Also, therapeutic communities reject the dominance of roles and insist instead on education for personhood. The emphasis on developing one's potential as a person is so pervasive in the TC culture that it includes not only those persons who are in the residential facilities or outreach centers but also their families.

A sixth phenomenon of therapeutic communities is the parallel education of families, with family defined as "significant others." The education of families by the Family Association of Daytop Village provides a powerful support system both for the residents and their non-resident family members. The Family Association educates the families, who also are in need of new ways to be and to do.

The first major learning of a "new" parent in the initial "orientation" meeting is that parents are primarily persons rather than primarily parents of a drug addict. To begin to feel like a person, with an identity and personal value, is quite a change in self-concept from that of a guilty parent. That learning occurs is documented by the large number of persons who give the Family Association its vitality.

Perhaps the emphasis on personhood for everyone avoids the troublesome dichotomy of a goal-oriented versus a role-oriented society. A person who is advancing toward wholeness learns how to integrate goals and roles in ways that are consistent with his perception of his identity.

The saying in therapeutic communities that "the only constant is change" has considerable credibility in practice. It would seem appropriate that an educational model that confronts persons with their need to change would also be willing to undergo change in its procedures and structure. Change is the eighth element of the TC environment to be included in these observations.

Daytop Village, as experienced between March, 1980 and September, 1985, has evidenced quite a break from its own past. The change which is the most germane for this discussion is the movement from a treatment center for drug addicts to an educational center for the development of whole persons. Daytop Village has broadened its base, reflecting in part a heightened awareness of the value of academic as well as experiential learning. The new inclusiveness means that we are willing to recognize the worth of the recorded experience of others in addition to our own experience.

Don Ottenberg, a long-time member of the TC family, contributed to an understanding of different but equal when he originated the descriptive terms "experientially-trained professionals" and "academically-trained professionals." Hobart Mowrer, regarded as the modern philosopher of the self-help movement, suggested that the ideal might be an alloy, a combination of the two. The alloy is becoming a reality at Daytop Village by greater numbers of experientially-trained staff persons seeking academic training and by a larger number of academically-trained persons becoming staff persons. Both of these trends represent a natural evolution, but the third kind of alloy is a product of the system itself.

Mention has already been made of the Daytop Miniversity. The Miniversity group is being simultaneously academically and experientially trained. A therapeutic community with an academic component is building one of its own change agents if the Miniversity is making a meaningful difference. It is recognized within TCs that to effectively educate for wholeness the TC itself has to be willing to change and to grow. The Miniversity at Daytop Village would seem to be evidence of such a willingness.

Perhaps the integrating factor of Therapeutic Communities that gives stability through all the changes is a ninth characteristic: the pervasiveness of the values of honesty, responsibility, and involvement. The question frequently arises in American education where church and state defend their territory: "Whose values are going to be imposed on whom?" That education could be value-free is a myth; to insist on detachment makes the statement that detachment has value. It would seem to be self-evident that it would be impossible to educate for wholeness without teaching values. However, we need not dwell on this dilemma; whether we should or should not teach values is not an issue in TCs. Teaching values is the top priority. Even when residents do not graduate, we console ourselves that we have affected their values for the better.

We do have our own dilemma in TCs, however. How do we define "spiritual" or "religious" values? At the First World Conference in Sweden in 1976, Hobart Mowrer analyzed the nature of the self-help movement. He concluded that TCs are religious, for they are reconciling environments which reconcile persons to other persons. Mowrer interpreted the caring, sharing, interdependent relationships of therapeutic communities as a kind of horizontal theology--the relationship between persons as distinguished from a vertical theology--the relationship between persons and God. A tenth feature of therapeutic communities is their basically religious nature.

Americans would tend to know more about Christianity than about any other world religion. Christianity and therapeutic communities are very compatible ideologically. Both center on love, involvement, and relationship. If we think of spirituality as detachment from the world, in that sense, Christianity is not particularly spiritual. The Christian God is so involved that He became man. Then, a model having been provided, persons are advised to love one another "as I have loved you."

We experience a great deal of responsible love, concern and involvement in TCs. If we follow through with Mowrer's logic that to care profoundly about our neighbor is religious, then we could agree that therapeutic communities are religious.

An American psychiatrist, Robert Coles, recognized for his work with children in crisis, told this story to a university audience attending a "Religion in Life" lecture at an American university:

> The son of a Florida orange grower became, over time, friendly and involved with the migrant children working in his father's groves. Sometimes he even worked in the field beside them. The closer he got to them the more upset he became about their living conditions. He began to raise his concerns with his parents and to interject it in discussions at school. The family was very religious and the boy wanted to know whether Jesus would have wanted people treated this way. He began to have dreams that his hands were covered with blood. Finally he even began to challenge his parents about their treatment of the migrant workers.
>
> At the urging of teachers and friends his parents took him to a psychiatrist. After "therapy" the boy ceased being an advocate for the children in the fields. He ceased being concerned about anything except fitting into his parents' world.

As reported, Cole's evaluation of the function of the psychiatrist in this instance is that the psychiatrist had been used to "amputate" the boy's conscience rather than to give it direction. Coles indicated that conscience doesn't just happen, it has to be nurtured. "What are you doing about nurturing the conscience of the young people in your care?" is not a question we ask to evaluate public education, but it is a question Coles asked the clergy in the audience, the designated religious educators.

Mowrer, a religious psychologist and one-time psychoanalyst, said repeatedly that it is not our over-developed, repressive conscience which gets us into trouble, but our under-developed conscience. Part of the growth toward wholeness in therapeutic communities is the nurturing of conscience--the capacity to distinguish between right and wrong, to feel guilty when we are wrong, and to change our behavior.

Therapeutic communities have a number of so-called unwritten philosophies. The first is trust; in other words, have faith. Another is truth. A third is "responsible love and concern." Three of the philosophies are similar: it's better to give than to receive; understand rather than be understood; and you can't keep it unless you give it away. These philosophies do not represent the values of the "secular" culture. By a simple process of deduction, some of us would therefore tend to think that since they do not reflect "secular" values, but they do reflect values, then they must reflect spiritual values.

We are ambivalent and uneasy in TCs when we talk about spiritual values. We would seem to be in the reverse of the more usual condition which is to profess values without reflecting them in practice. We give spiritual values meaning in our relationships in TCs, but have an adolescent shyness about admitting that we do.

At the final plenary session of the World Federation of Therapeutic Communities Conference in Rome in September of 1984, one of the speakers forecast we would be talking more about spirituality in therapeutic communities as we continue to meet. It has been impossible to think about education for wholeness without including spirituality. As we mature in therapeutic communities, it seems natural that we would gradually become more open about our spiritual selves and less reluctant to be articulate.

A Swiss psychiatrist, Paul Tournier, in a book, The Whole Person in a Broken World, quotes a colleague who reportedly said, "Men are different, but they are neighbors. Men are persons in whom God's spirit has become incarnate." Tournier added, "Ultimately it is the spiritual destiny of man which is being played out in his psychological and artistic destiny, and in his mental and intellectual destiny."

Therapeutic Communities present an intriguing paradox. They have gone forward by going back, going back to our roots and our values, particularly to the spiritual value of recognizing the inherent dignity and worth of each person. Therapeutic communities make a unique statement to the total educational community, for they demonstrate that in a broken world it is possible to educate for wholeness.

TC'S CONTRIBUTION TO MULTICULTURAL PREVENTION

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In medicine, social work, criminal justice, mental health, alcoholism or drug addiction there is no treatment that is not also useful for prevention. But the field of drug abuse prevention has not benefited much from the knowledge base built by the treatment field because there is a large gulf created by professional turfdom and competition for dwindling dollars.

This conference on therapeutic communities and this workshop on prevention offers a unique opportunity to look at the basic components of the therapeutic community and compare it to what we know (or believe) to be important to prevention. First, however, let's consider some differences in the role of prevention vs. treatment.

Prevention usually seeks to insure against vulnerability to drug and alcohol abuse by impacting early in one's life to help provide the balance, strength and consciousness necessary to avoid the pitfalls of chemical abuse. Treatment intervenes later, after abuse has already begun. But despite the difference in timing their aims are the same, i.e., to provide the balance, strength and consciousness necessary to render us drug-free (or at least abuse-free).

Another difference between treatment and prevention is the size of their target populations. By definition, therapeutic communities treat relatively small numbers of addicts while prevention attempts to empower communities. But, again, whether personal empowerment or community empowerment, the road to empowerment is the same.

The National Institute of Drug Abuse (NIDA) asserts that, although the most expensive, the therapeutic community is the most effective method of treatment used in the United States. The most important thing therapeutic communities have always done is exactly what the recent Rand Corporation study of prevention programs recommends, i.e., it offers not one, but several coordinated techniques and integrates the client's experience with his or her peers and significant others. It represents a wholistic approach. It tries to impact all the important aspects of one's life. The therapeutic community doesn't just feed information, it deals with food clothing, shelter, responsibility, relationships, respect, employment readiness, education and training, physical and mental health, and culture. Therapeutic communities make you aware of your environment and provide you with the skills to survive and develop in that environment. They provide the courage and consciousness to change the environment to the extent necessary for collective growth and development.

These are exactly the principles the Multicultural Prevention Resource Center MPRC promotes as the goals and objectives of drug prevention, especially with regard to prevention among the most drug-involved and at-risk groups, i.e., ethnic and social cultural populations such as brown, yellow, red and black people, gays, women, seniors, youth cultures etc.

Therapeutic communities have developed a greater multicultural consciousness than other treatment methods be-cause the residential facility physically contains many different cultures and orientations under the same roof and has had to find ways to weld this disparate mob into a family without assaulting (or insulting) cultural differences. Therapeutic communities are multicultural families. It must be admitted, however, that some therapeutic communities have developed greater multicultural consciousness than others. This is in part because a multicultural residential facility faces two problems:

1) It seems easier to melt different cultures into a single pot than to take the time to celebrate each different culture, and the fight against cultural chauvinism and narrow nationalism is a constant one.

2) The therapeutic community itself has involved a rather unique culture and there seems to be a tendency to superimpose the therapeutic community culture on the various cultural groups. Also, the therapeutic community culture is more closely related to white, American, male culture than to any non-white or minority culture.

But overall, therapeutic communities have a rather progressive political and social consciousness and history. They go a long way toward fighting racial and sexual bias within the therapeutic community and have been known to get involved in community issues and demonstrations. Again, these lessons and principles could be very useful to prevention programs because from the point of view of MPRC, that's what prevention is all about, i.e., political, social and economic cultural empowerment of communities.

Prevention is the coming megatrend in drug abuse as well as human services as a whole. There are three recommendations MPRC makes to advance prevention and to advance the contribution therapeutic communities can make to prevention now and tomorrow:

1) Therapeutic communities must study, analyze and isolate the many valuable prevention techniques and principles they advocate and market them as important components of prevention programming.

2) Prevention programs should learn as much as possible about therapeutic communities' techniques so as to incorporate them into their prevention models, where appropriate.

3) Dialogue should commence among all drug program personnel so as to distill the valuable knowledge accumulated over the last 20 years of treatment and apply that knowledge appropriately to prevention.

The Multi-Cultural Prevention and Resource Center stands ready to participate and assist in the above-mentioned recommendations.

THE ROLE OF EDUCATION IN THE TC

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Each year in the United States, thousands of individuals seek treatment for substance abuse problems of one kind or another. Outpatient counseling or psychotherapy of one form of another is adequate for some; however, an ever-increasing number require residential treatment in a therapeutic community designed to treat substance abusers.

Since the number of such therapeutic communities has rapidly grown as has the variety of formats offered by such programs, much debate has arisen respecting the following question: "What are the necessary components that should be included within the structure of the therapeutic community?" The present discussion is concerned with just one facet of treatment....that of the role of education.

Before proceeding with further discussion on the subject, it is important to address the following question; namely: Is there a need for therapeutic communities to include within their treatment structure an educational component?

A look at the educational background of individuals who seek residential treatment for substance abuse can provide useful information for answering the above question.

Individuals within this target population generally fall into one of the three groupings listed below: (See Table 1)

Group 1: Approximately 51% of those entering the therapeutic have not completed high school or the equivalent thereof.

Group 2: Approximately 49% of those seeking residential treatment are high school graduates with some even completing some college coursework. However, of this group very few actually have 12th grade level skills. In fact, only half of the 49% with a 12th grade or beyond education have reading, writing and basic mathematical abilities at or beyond the 12th grade level.

Table 1

Highest School Grade Completed

Years of Education	Percent
Grade 8 or Less	3.77%
Grade 9 - 11	47.17%
High School Graduate	37.74%
Some College	11.32%

*Based upon 1984 Tuum Est, Inc. Northern Facility client population.

For example, of the 49% with a 12th grade education or beyond, only 25% of the total 1983-1984 sample population demonstrated reading, writing and basic mathematical abilities at or beyond the 12th grade level when administered Form B of the General Educational Development Pretest on the above three basic subject matter areas. Thus, it clearly can be seen that the skills of many of such clients have become "rusty" due to lack of use or other factors related to their substance abuse.

Group 3: Included in this group are persons who have completed high school or some college but who have no skill deficits, i.e. persons who passed all three of the above-mentioned sections of the Form B General Educational Development Pretest. Twenty-four percent of the 1983-1984 client population can best be characterized by the above "Group 3" description.

The above breakdown demonstrates the existence of a need for educational assistance within this target population. Some might argue, however, that the role of the TC is not that of an educational institution, but rather is that of a treatment center to provide clinical services such as psychotherapy. These same individuals may feel that including an educational component within the structure of the therapeutic community is an unnecessary and therefore inappropriate adjunct to psychotherapy.

The purpose of the present investigation is in no way to belittle the critical role of individual and/or group psychotherapy, but rather is to show that education is also an important factor in affecting behavior change and therefore should be included in the treatment plan of the therapeutic community on a systematic basis. Besides establishing the need for an educational program within the confines of the therapeutic community, the present discussion also outlines the subject matter areas that should be included in the curriculum of such programs. However, before going into a discussion of what should be included in the curriculum of educational components, it is important to discuss the benefits of such a program.

These five major benefits are discussed below:

Benefit #1: Concerns those individuals who dropped out before completing high school (or in some cases grammar school.) An educational component within the TC provides these individuals with opportunity to complete the course they need to bring their educational level up to that of a high school graduate by providing the required coursework needed to obtain a high school diploma. A G.E.D. preparation course, too, may be offered to prepare clients for a high school equivalency exam such as the G.E.D. (General Educational Development) test.

The above is critical to treatment, in part, because of the finding of the U.S. Bureau of Labor Statistics over several past years that individuals who are high school graduates fare much better in today's job market than their non-graduate counterparts.

Obviously the benefits such individuals receive are far more than monetary and also involve the self-reinforcement that comes from finishing their education and obtaining their diplomas of G. E. D. Certificates rather than giving up, as many have done in the past.

Benefit #2: Concerns persons who have a high school or better education but do not have skills that measure up to 12th grade standards.

It should be obvious that merely possessing a high school diploma is a meaningless phenomenon if an individual's skills have fallen well below the 12th grade level, as happens in many cases (see Table 1). Therefore, individuals in these circumstances too, greatly benefit from an educational component because it provides them with an opportunity to refresh or renew their basic educational skill deficiencies and bring them up to what they once were (at or beyond the 12th grade level).

Benefit #3: Concerns all three of the educational groups listed above, even those with high school and/or college coursework with strong skills and no skill deficits. It involves the healthy effect that exposing clients to education and the learning process has within the confines of the therapeutic community.

In many instances, this healthy effect is derived from the fact that many clients have not been in contact with the learning process or the educational setting in years.

In fact, many clients, even those with good educations, report they have not exercised their mental faculties in the months (in some cases even years) prior to entering treatment when they were engaged in spending large amounts of their time under the influence of drugs and/or alcohol.

Truly, the primary benefit of including an educational component within the therapeutic community structure is that clients "learn how to learn" again and experience both the internal non-tangible reward of self-reinforcement and external tangible rewards such as completing required coursework and getting passing grades.

Unlike many traditional educational programs, these rewards should be built into the well-structured, but client-oriented, educational component and thus should be inherent for the majority of clients involved in such classes. This is because a primary goal of such programs should be to provide clients with a successful encounter with the learning environment and educational processes.

When clients experience these successful encounters with learning, such experiences provide them with a basis for viewing themselves in a more positive light and thus fostering a heightened level of self-esteem.

Benefit #4: Is related to Benefit #3 and concerns the fact that, overall, clients seeking residential substance abuse treatment typically have poor study habits, work methods, and problems solving methods (See Table 2 for mean percentile scores).

Table 2

Mean Survey of Study Habits and Attitudes (Brown-Holtzman, 1965) Percentile Scores* based upon client population - Tuum Est, Inc. Northern Facility 1984-1985 Academic School Year

Category Measured	Pretest	Mean Post Test
Delay- Avoidance	27.8 percentile	36 percentile
Work Method	48 percentile	59 percentile
Teacher Approval	51 percentile	67 percentile
Education Acceptance	36 percentile	39 percentile
Study Habits	36 percentile	44 percentile
Study Orientation	37 percentile	46 percentile
Study Attitudes	40 percentile	50 percentile

*Note: The above 1984-1985 percentiles are based upon Form C, Grade 13 norms. Further detail respecting the precise variability of scores may be obtained by contacting the author.

As can be seen from Table 2, an educational component within the therapeutic community can be associated with changes in study skills such as those measured by the Survey of Study Habit and Attitudes (Brown - Holtzman, 1965). Such mean scores show a significant increase in measurable study habits and skills from pretest (given at the onset of educational therapy) to post-test (ad ministered after a three-month junior college level course in study skills within the therapeutic community). Such a relationship is significant because good study skills and work methods are known to correlate highly with academic success and successful performance in a job setting. These are crucial to clients upon re-entry.

Benefit #5: Concerns the fact that many clients of such therapeutic communities report negative attitudes toward teachers and educational institutions (see Table 2) and many times have a history of poor relationships not with teachers, but also with other authority figures such as parents, bosses at work and law enforcement officials.

Including an educational component within the confines of the therapeutic community provides clients with the additional opportunity of interacting with an authority figure, namely the teacher, within a controlled atmosphere. This situation many times brings to the fore past problems the client has had in dealing with such persons. In fact, many clients entering treatment report negative and many times humiliating interactions with school and with teachers.

A well-structured but client-centered educational component within the therapeutic community can be beneficial by endeavoring to provide positive interactions with the instructor and with the learning atmosphere that are so greatly needed, and so often associated with changes in attitude toward teachers, education, and authority figures in general.

In summary, it can be seen from the above five benefits discussed, that including an educational component within the structure of the therapeutic community can be of benefit to clients in several ways.

However, it is one thing to demonstrate a need for such a program, and quite another to outline the specific components that should be included in one. These are discussed below.

When developing an educational curriculum within the confines of a therapeutic community, it is important to first assess relevant intellectual, educational, and psychological characteristics of the target treatment population. With respect to the above-mentioned Tuum Est, Inc. Northern Facility educational component, several standardized tests are administered for various purposes (see Table 3 for an outline of the client characteristics assessed and the tests used).

Table 3

Characteristics Assessed, Tests Used to Assess, and Mean Test Score Based Upon Tuum Est, Inc, Northern Facility Client Population 1984-85 Academic School Year

Client Characteristic	How Measured	Mean Score
Intelligence	California Short Form Test of Mental Maturity - advanced Grades 9 - Adult	97 Total Intelligence Quotient
Self-Concept or Self-Esteem	Tennessee Self Concept Scale	39 Percentile of mean positive scores (self-esteem)
Educational Grade Level for High School or Beyond Clients	G.E.D. Pretest Form B	43 Average Score on all 5 subsections

Data collected from these test during the 1984-85 school year reveals that, on the average, clients in residential treatment at Tuum Est, Inc. Northern Facility can best be characterized as:

1. In the average I.Q. range.
2. With a lower-than-average level of self-esteem or self-concept.
3. With a demonstrated level of academic performance equal to or beyondgrade 10.

With These factors in mind, the picture that emerges of the typical client in treatment at the abovementioned therapeutic community is that of

1. One who has either dropped out of high school or graduated in the past but now has basic skills which are below the 12th grade level, and

2. One who has low motivation to learn, and little confidence in his/her ability to learn.

Given the above, the question that arises is: Precisely what can the educational component do to assist clients in affecting an improvement in the skill and attitude areas mentioned above. Five suggestions are outlined below:

1. It is important that at the onset of educational therapy, clients be provided with a clear-cut set of objectives; i.e., the client should be informed as to both the reasons why a school program is required and what specific knowledge and skills she/he can expect to gain in class and how these prove useful in their present therapy and later re-entry process.

2. If testing services are available, each client should undergo intelligence, educational achievement, and, if possible, personality testing, to aid the instructor in both placing the client in his/her proper grade level of materials and understanding relevant to personality factors.

3. Many times the modes of individual and group psychotherapy clients receive in TC's leave them open and quite vulnerable to experiencing the wide gammet of human emotion, including pain and hurt.

It is important then, that educational classes within the community be viewed as an extension of the therapy provided rather than as a separate entity, and that the instructor or teacher be a sensitive individual in tune with both his/her own personality and the personality make-up of the chronic abuser.

4. In terms of teaching technique, it is important that the instructor or teacher organize the material to be included in each subject (whether it be elementary, high school or junior college level) into short, easy-to-master segments.

This is critical because the chronic substance abuser in residential treatment has difficulty sitting in class for long periods of time and also has difficulty with completing lengthy, complex assignments. Thus, if assignments are too long or demanding, clients of this character type will generally simply become frustrated, give up, and do nothing.

On the contrary, if clients are given shorter, more reasonable assignments, they have a better chance of giving correct responses on assignments, tests, etc.

Correct responses lead to a feeling of accomplishment...of success and improve the client's self concept and let her/him see that he/she, in fact, is an intelligent being, that she/he is capable of learning new things and improving his/her present status, educationally and in many other ways.

Thus when developing classes for the therapeutic community it is just as important to give consideration to the way in which you teach as it is to consider what you teach, i.e. the specific topics or subjects you teach.

5. Finally, how can one know what courses should be included in the curriculum of a therapeutic community?

There is certainly no magical formula or easy answer to this question. However, if you have followed suggestion 2 mentioned above, you are aware of the general pattern of educational need of the program in question and can better select from elementary, high school or junior college course offerings (perhaps utilizing more than one level of instruction as is often times needed.)

In conclusion, it should be evident that the providing of educational assistance programs within the therapeutic community offers a meaningful adjunct to traditional clinical techniques and represents truly exciting and promising direction for the future.

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THE EFFECTS OF A SCHOOL-BASED EARLY INTERVENTION PROGRAM ON HIGH RISK PRE-TEENS

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INTRODUCTION

The Self Awareness Center is a component of Project 25, Community School District 25's Drug and Alcohol Prevention and Intervention Program which has been funded by the New York State Division of Substance Abuse Services since 1971. Project 25 provides education, information, individual counseling, group counseling, family counseling, crisis intervention and referral services to staff, students and their families in 22 elementary schools and 6 junior high schools in a multi-ethnic, socio-economic middle class community with pockets of families on public assistance.

The Self-Awareness Center was developed in response to an in-house evaluation of Project 25's school program. Each staff member articulated the needs of a specific target population among the 6th grade students. The problems of these students appeared to stem from a wide range of family situations including a recent divorce of the parents, a second marriage of the parents, both parents working, older siblings involved in drug abuse, alcoholic parent's, drug abusing parent's and loss of a parent. These problems included poor self-image, depression, loss of self-confidence, isolation, feelings of abandonment, alienation, poor peer relation ships, resistance to authority, decrease in self-discipline, and a drop in academic grades. Research in the treatment field indicates that drug abusers suffer from the same feelings and act out these feelings similarly- i.e. decrease in self-discipline, resistance to authority, and dysfunctionality either in school or in the job market.

In addition, from our experiences with the early adolescent (7th - 9th grade, 13 - 15 years old), who was already experimenting with and/or abusing drugs, we knew that there was a high correlation to the probabilty of their younger siblings becoming involved at an early age.

Project 25 staff therefore recommended that an intensive program of individual, group and family counseling in conjunction with remedial instruction be offered to students who were "at risk" as a result of multiple family problems in order to provide early identification, diagnosis and intervention. A pilot program was introduced and implemented for one year in 1974/75. At the end of that year an internal evaluation showed significant changes had taken place in each student in behavior, self esteem and academic performance. Unfortunately, in the summer of 1975, Project 25"s budget was substantially cut as a result of changes in the administration of the funding agency and changes in policy and guidelines for funding. Consequently, Project 25 could not continue or expand the Self Awareness Center at that time.

Once again, at the close of the school year 1979/80, when conducting our internal evaluation for that year, Project 25's elementary school staff expressed serious concerns regarding the increase in the number of 6th grade students identified as "high risk" youngsters from multiple-problem families. In addition to the problems stated above, there were new problems. With the increase in our district in the number of immigrant families and non-English speaking families, problems related to cultural differences, problems related to rejection, isolation, antagonism and scapegoating had become more frequent and serious. Other new problems included an increase in adolescent criminal involvement, an increase in the incident of incest and child abuse, an increase in alcohol and drug abusing parents, and an increase in children becoming sexually active at an earlier age - all of which further compounded the effects on the individual child and resulted in negative acting-out behavior.

DESCRIPTION OF PROGRAM

Goals of the Self Awareness Center:

1. To identify 6th grade students who are experiencing difficulty in school or who exhibit dysfunctional behavior, all of whom may be considered "at risk" of becoming alcohol and/or substance abusers.

2. To provide these selected students with intensive group, individual and family counseling in order to:

   a) improve self-image

   b) develop positive decision-making skills

   c) develop problem-solving skills

   d) improve communication between students and parents

   e) help students decrease negative acting-out behaviors

f) help students become responsible for their behavior

3. To provide support for families in crisis.

4. To enhance the over-all classroom atmosphere and environment by providing intervention services to difficult students.

5. To provide an evening parent group focusing on parenting skills.

Program Services:

The Self Awareness Center has been implemented for the past 5 years in essentially the same form with some adjustments as we learned more from the extensive evaluations done each year. The initial task was to select the schools. Early in June a district circular was issued to all elementary school principals announcing the advent of the Self Awareness Center for the Fall term. The circular informed the principals that selection of the schools to receive the services (2 schools per semester) would be based on need (number of high risk students), available space (minimum of 2 rooms), request of the principal, and Project 25's prior experience with the school. These responses were reviewed and analyzed in conjunction with Project 25's knowledge of and experience with the students in these schools and/or their siblings. Once the schools were identified, one was designated to receive the Self Awareness Center services 3 mornings a week and the other 3 afternoons a week for 2 cycles of approximately l semester each (half a school year).

Intensive self awareness groups were held twice a week for approximately 1 hour per group for approximately 14 weeks. Individual counseling was provided weekly for a minimum 1/2 hour session per child. Articulation with school staff, case consultation, follow-up and feedback took place on a regular weekly basis. Outreach to families and family counseling wee an integral part of the program. In addition to contacts with individual parents, at least 2 parent group per cycle were offered to provide orientation to the program, dialouge between staff and parents, and an opportunity for parents and children to interact in a group setting. Weekly evening parent groups were also offered.

In the first year of the program tutorial services were provided. This proved to be difficult to coordinate with individual classroom teachers especially in those schools that operated their 6th grades on a departmental basis involving different teachers for major subjects. In addition, many of the selected students were already receiving remedial instruction through other school programs. We therefore decided to eliminate the tutorial services. However, we discovered that even without the additional academic services each of the children's academic performance improved as their acting-out behavior changed.

Program Staff:

Staff for the first year included a coordinator, school social worker, and a family worker. This has remained essentially the same in terms of positions with a second family worker added when budgetary considerations made it possible. However, changes in personnel filling these positions have resulted in varying needs for staff orientation and training and impacted on the responsibilities of the coordinator for upgrading skills and developing teamwork.

Selection Process:

A. Referral Procedures

1. Orientation of school administration, faculty and PTA -

Self Awareness Center staff presented the program at grade conferences including 5th and 6th grade teachers and the principal, and at a PTA meeting in order to acquaint both groups to the concept, philosophy, design, criteria for selection, and behavioral goals of the program.

2. Reasons for referral

School staff were asked to refer students fitting one or more of thefollowing criteria:

a) poor self-image

b) holdover (retention from promotion)

c) disorganization in school work

d) anxiety

e) poor work habits

f) short attention span

g) negative attitude towards school

h) hostility towards authority figures

i) incomplete classwork/homework

j) negative leader

k) follower of negative peers

l) lack of responsibility

m) poor interpersonal relationships

n) fighting

o) disruptive behaviors

p) alcohol/substance use or experimentation

q) recent family crisis; i.e. serious illness, separation, divorce, divorce, death

r) alcohol/substance abusing parent or sibling

s) poor parental supervision

t) withdrawn or depressed behavior

u) truancy

v) frequent absences

w) habitual lateness

It is stressed to the referring person that the dysfunctional behaviors should be of fairly recent origin (within the past 2 years) and, to the best of his or her knowledge, not be due to long-standing, deep-rooted emotional and/or psychological pathology.

B. Intake and Screening Process

A profile of each referred student was completed from the permanent school record cards including recent grades, city-wide reading and math test scores, personal and social adjustment, general health, basic family information, previous efforts to help the student, and any referrals or placements. Each youngster was then interviewed by staff and asked to fill out an intake card consisting of 3 basic components: 1) routine questions such as name, age, address, grade, telephone number, place of birth, primary language spoken in home; 2) family structure including parents; marital status, parents' places of birth, relationships and work or school status of persons living in the youngster's home; 3) questions designed to communicate a sense of how the youngster spends after-school time, his or her self-image, whether there are any concerns around the issues of alcoholism, physical or sexual abuse. This interview also affords an opportunity for the staff to explain the program and respond to the student's concerns or questions. Additional sociological, academic and behavioral information was obtained from the guidance counselor and other appropriate school staff.

C. Parent Contact

Parents were contacted to orient them to the program and to request written permission.

D. Staff Consultation with Director

The Self Awareness Center team met with the Director of Project 25 to conduct an in-depth review of all intake and screening material. Children were then selected for each group based on the following considerations:

1. number of reasons for referral and degree of dysfunction;

2. ability of youngster to function in and benefit from group;

3. staff's assessment of appropriateness of referral (e.g., can youngster interact productively with peers? Is presenting behavior a result of long-standing pathology? Is child in therapy or counseling?)

4. the need to balance groups, in terms of ethnicity and gender (e.g. the difficulty in establishing a working group if there is only one female in a group of males, or one white in an otherwise black group);

5. receipt of written parent permission

E. Principal Consultation

Consultation was held with the principal to inform him or her of the outcome of the screening.

F. Alternate Recommendations

If a child was referred and was not selected, appropriate recommendations were made for alternate referrals.

PROGRAM MEASURABLE BEHAVIORAL OBJECTIVES:

Measurable behavioral objectives were developed for the program in general as well as individual treatment plans including goals and activities specific to each child. The overall measurable behavioral objectives are listed as follows:

1. By the end of the program cycle at least 16 students will have been screened and accepted for the Self Awareness Center.

2. If a student had been truant, there will be an improvement in attendance by end of cycle, as measured by school records.

3. If a student had been habitually late, there will be a decrease in lateness by the end of cycle as measured by school records.

4. Each student will improve in at least one academic area, by the end of cycle, as measured by school records.

5. If a student was experimenting with alcohol and/or substances, the experimentation will cease by the end of cycle, as measured by self-reports, parent reports, and/or peer reports.

6. If a student had exhibited negative behavior, i.e. fighting, calling out, hostility towards authority figures, there will be a decrease in the number of incidents by the end of cycle as measured by teacher and principal evaluations.

7. The student will show an improvement in at least one area of personal adjustment by the end of cycle, as measured by teacher, principal, and parent evaluations.

8. The student will be able to identify at least 3 positive qualities about himself/herself by the end of cycle as measured by pre and post test questionnaire.

9. The student will show an improvement in self-image by the end of cycle, as measured by pre and post questionnaires.

10. The student will be able to express at least 3 responsibilities and demonstrate how at least 1 responsibility was fulfilled by the end of cycle, as measured by contracts through individual counseling sessions.

11. By the end of cycle, the student will be able to cope with his or her problems more effectively by identifying at least 1 problem and how it was worked out, either in group or in individual counseling.

12. By the end of cycle, family relationships will have improved, as measured by parent evaluations.

METHODS OF EVALUATION

The evaluation design of the program was developed at the same time the program was developed during the Summer of 1980. It was felt that every person who came in contact with the student should provide feedback and evaluation. Therefore, the evaluation of the Self Awareness Center involved: students, teachers, principals, parents, and Project 25 Self-Awareness Center Staff.

Pre and post tests measuring self-image were administered to each student. During the last week of the cycle, each student completed Group Evaluation Form which is a self evaluation of the group dynamics and group process.

Since teachers initially identified the behaviors for which the students were referred, in consultation with the principal and Project 25 staff, the teacher and principal evaluation forms were administered at the completion of the cycle. Both groups were asked to evaluate the behaviors for which the students were referred and also to indicate any changes they observed in other behaviors. The range of measurable change included: no change, slight improvement, marked improvement, regression.

Parent evaluations were more global because parents were not advised specifically as to why a teacher referred the student, since we felt this might be counterproductive to the receptiveness of the parent. If persons were unable to attend the final session, they were contacted by telephone, advised that a form would be mailed to them and asked to complete the form for our evaluation. The parent evaluation form consisted of three areas: general comments concerning the parents' perceptions of the benefits the children derived; positive changes they had observed in their children's behavior, and any additional comments they wished to make.

The Self-Awareness Center staff were required to maintain various records. These included an Intake and Screening Form, developing of specific behavioral goals for each student, ongoing progress reports for group, individual and family counseling and termination forms. The termination report evaluated the student's progress or lack of progress in accordance with the reason for referral and the specific goals established for each student.

CONTINUING SERVICES

In an effort to implement a longitudinal study through the 9th grade, Project 25 staff were used to provide supportive services where they were needed, and, if not needed, to monitor academic and behavioral performance to determine the carryover effects of the program. Since all other regular services had to be maintained, the limitations on staff time had a serious effect on the thorough scientific implementation of this study.

In the 5 years the Self Awareness Center has operated we have services approximately 125 students in a total of 14 groups in 7 different schools. To help us zero in on an assessment of the program and how it impacted on youngsters we have selected one group and provided case histories for each young-ster. We have also indicated the final assessment and recommendations at the close of the program plus a brief description of continuing services and status of the client through 7th, 8th, and 9th grades.

This group came from multi-ethnic, middle socio-economic families living in Flushing, Queens, New York. They entered the program at the beginning of the Spring term of 1982. Their progress was followed through June, 1985 as they progressed through Junior High school. Evaluations were done by teachers, principal, Project 25 staff, student and parents as described in the methods of evaluations.

Brief Case Histories

Student #1 (Female) - Age at Intake: 12 yrs. 9 mos.

Reason for Referral: Holdover in 2nd grade, poor self-image, lack or responsibility.

Background: Intact family, Spanish-speaking (Columbian), youngster in Resource Room, one older sister. Test Scores (4/81): Reading- 5.2; Math- 4.5 Grades(6/8): Failed Math, passed other subjects. Personal Adjustment (6/81) - Satisfactory

Assessment & Recommendations at Close of Program: Overall slight improvement in presenting behaviors, slight improvement in academics; followup services - individual counseling.

Followup: 7th grade - Individual counseling, referred for private therapy. 8th grade - attendance, grades and behavior improving, receiving followup services (periodic monitoring) only.

Present Status: 9th grade - good adjustment, graduated junior high school, no substance use.

Student #2 (Male) - Age at Intake: 12 yrs., 3 mos.

Reason for Referral: Poor self-image, short attention span, holdover in 4th grade, disruptive, dissociates (tunes out in classroom), child of alcohol abuser.

Background: Parents divorced for 6 years, child lives with father, mother was an alcoholic, sees mother once a week, child attends Alateen, in Resource Room. Test Scores (4/81): Reading - 5.4; Math - 6.4

Grades (6/81) - passed all subjects. Personal Adjustment (6/81) - Unsatisfactory in self-control.

Assessment & Recommendations at Close of Program: Slight improvement in all presenting behaviors except for no improvement in disruptive behavior; followup services - continue in private therapy.

Followup: Removed from public school system by father. Present Status: unknown.

Student #3 (Male) - Age at Intake: 11 yrs., 1 mo.

Reason for Referral: Poor self-image, inappropriate anger.

Background: Intact family, Greek-speaking, 4 older brothers, 1 older sister, 1 younger brother. Test Scores (4/81): Reading - 6.3; Math - High School level. Grades (6/81): Passed all subjects. Personal Adjustment (6/81) - Unsatisfactory in self-control.

Assessment & Recommendations at Close of Program: Slight to marked improvement in presenting behavior; followup services - periodic monitoring.

Followup: 7th grade - monitoring only, continued improvement. 8th grade - demonstrated leadership qualities, on Audio Visual Squad.

Present Status: 9th grade - excellent adjustment, graduated from Junior High School, no substance use.

FINDINGS AND CONCLUSIONS

1. General Findings

Based on the teacher, principal, parent and Project 25 staff, there is a population of students in Community School District 25 who evidence school difficulties, who also have familial problems and are in need of intensive services. The intensive services are needed to provide for early identification, diagnosis and prescription including group, individual and family counseling. These findings corroborate the initial Project 25 staff perception of need.

2. Responses and Perceptions

Principals and assistant principals were very supportive of the program. Some of the teachers were resistant at the outset to having children removed from class but became more accepting as they observed he positive behavioral changes exhibited by students. Generally, parents were receptive to their child entering the program. Most of these parents had experienced being called to school many times for problems involving their child. Once a trust level was established, most students were very verbal, open and had little difficulty in identifying their problems. In many instances, they were able to identify other problems in the family.

3. Other School Services

Some students had been referred to the Committee on the Handicapped and were evaluated as inappropriate for Special Education. Some were referred but parents did not give permission for testing. A few were placed in the Resource Room and/or received pupils with Special Educational Needs services. Through the efforts of Self Awareness Center staff some students were identified as needing special services. Although the school did not follow through on staff referrals to Committee on the Handicapped our findings were validated when these students were tested by private agencies to which they were referred. We found that there is a population of acting-out students who are not being referred to other school services and as a result their behavior either shows no improvement or deteriorates. There is also a population of acting-out students whose parents refuse to allow the child to be tested for diagnosis and evaluation. The Self-Awareness Center then becomes a first step in identifying problems and providing referral services.

4. Specific Findings

(a) Of the children who completed the program, 85% exhibited at least one positive behavioral change.

(b) The number of positive changes per child ranged from one to thirteen.

(c) Many children improved in at least five behaviors.

(d) Most of the children (75%) exhibited improved behavior in areas for which they were not referred.

(e) In some cases, children were identified early in the program as inappropriate because of an inability to function in group. These youngsters were referred to the School Based Support Team for testing. In all cases, where this recommendation was followed, referrals for placement in Special Education were made.

(f) In some cases, recommendations for testing were not followed by the school. The parent was then referred by Project 25 staff for private evaluation and testing. Again, in all cases where this recommendation was followed by the parent. Evaluation determined the need for placement in either Special Education or private therapy.

(g) Most of the children referred for poor self-image exhibited improvement in the area.

(h) Every child referred for negative attitude towards school showed improvement in that area.

(i) In many cases where children were referred for specific behavioral problems, and improved in these behaviors, their attitude towards school also improved.

(j) Most of the children referred for negative acting-out behaviors showed improvement in those behaviors.

(k) Most of the students showed multiple behavioral difficulties ranging from a minimum of three to a maximum of seven.

(l) Most of the students accepted in the Self Awareness Center were reading on or above grade.

(m) Many of the students accepted in the Self Awareness Center were on or above grade in mathematics.

(n) Most of the children referred for poor interpersonal relationships showed improvement in this area.

(o) Some of the children who improved in the behaviors for which they were referred also improved in classwork and homework even though they were not referred for this.

(p) Most of the students who showed improvement in classwork and homework had shown improvement in other behaviors.

(q) Most of the students responded favorably to the group experience and no student had a negative response to the group leaders.

(r) Most of the students were able to identify ways in which the program had helped them.

(s) Most of the parents who participated in feedback sessions responded favorably to their child's participation in the program.

(t) Of the two students referred for truancy one showed marked improvement: the other student showed no improvement in truancy but did show improvement in two other areas.

(u) In every category for which there were referrals some children showed improvement.

(v) There are three males to every female who fit the criteria for the Self Awareness Center in the selected schools.

(w) The one student who had experimented with marijuana prior to admission to the Self Awareness Center stopped experimenting with the substance.

(x) Six of the families of the students in the program included an alcoholic parent.

(y) Some of the multi-problem families with whom the school had had prior contact with little or no success were identified by Project 25 staff as needing follow-up diagnostic services; however, the school administration was resistant to following through on Project 25 recommendations because of the preconceptions concerning the family's response.

(z) Every principal who had the program wanted it again.

(aa) The longitudinal study is difficult to implement because of the limitations of staff time since all other regular services must be maintained.

(bb) Many of the principals indicated that they would have liked to have the program in their schools but were unable to accommodate it because of space limitations.

5. Conclusions (Based on findings)

(a) There is a need for early indentification, diagnosis and intervention services (group, individual and family counseling) at the 6th grade level. The problems of self-identity, self-image, anticipation of the forthcoming transition to junior high school combined with family problems warrant the focusing and treating these problems in the protective enviornment of elementary school. In addition, it is a know fact that the earlier the intervention, the easier it is to reverse behaviors which are detrimental to self-image, self-identity, social, emotional and physical development and academic performance. This is very important with regard to the developmental tasks of the preadolescent and the early adolescent.

(b) Full cooperation of the principal, guidance counselor, and School Based Support Teams is essential for the success of the Self-Awareness Center program in reaching its goals regarding diagnosis of children.

(c) Multiple-problem families who previously were unresponsive to school Administrator's referrals do respond and follow through on a referral when they fully understand the reason for it.

(d) There seems to be a relationship among several variables.: one parent families, negative acting out behaviors and negative attitudes towards school. There seems to be an additional relationship between these variables and parent substance abuse. There seems to be no relationship between holdovers and any of the other indicators.

(e) There seems to be a school population in need of services (other than basic adademic tutorial services) for whom there are no traditional Board of Education services. The funded school based drug programs seem appropriate to meet the needs of these students to help students maximize their development and progress.

(f) It would seem that additional data would be helpful in order to determine whether or not the same conditions exist in other schools. Based on the fact that we have implemented the program in four schools, we would concluded that there would be a core group of students in most 6th grades that would fit the profile of the Self-Awareness Center child and thus be in need of intensive services. Space problems prohibit many schools from requesting the services.

(g) There is no evidence of boredom and/or anomie among the 6th grade students. All research in substance abuse indicates that one of the primary causes of adolescent substance abuse is boredom, particularly at ages 13, 14 and 15. This boredom progresses to anomie at ages 15, 16, and 17 and 18. The substance abuse problem progresses in incidence, variety and intensity with the chronological age. It would therefore, seem appropriate that the best possible point of diagnosis and intervention might be at 6th grade.

(h) One may conclude that when a negative attitude or behavior of a student is identified, intervention services provided resulting in positive changes, there is a corresponding positive change in classwork, class participation and homework.

(i) Any program that is developed for holdovers or behavioral problems (for example Resource Rooms) should include a component to address self-image, decision making, problem solving and responsibility for one's behavior.

(j) There is no basis for a correlation between Reading and Mathematics scores and students who are "at risk" of becoming substance abusers.

(k) Other than Reading and Mathematics scores, there are other factors that result in poor academic performance and students being held over i.e. family problems.

(l) Students who exhibit three or more of the variables included in this pilot program are in need of intervention services.

(m) There is a need to differentiate between recent behavioral and psychiatric indicators so that appropriate placements can be made for all students.

(n) Short attention span problems may be a problem of listening skills rather thatn an organic problem.

(o) The general climate and environment of the classes from which the children in the Self Awareness Center Program were drawn had to improve as a direct result of these students' positive changes. Therefore, all students in these classes benefited in their learning experiences.

(p) Since males outnumber females in the profile of referred students it would be important to further research the reasons e.g. do boys act out differently from girls or earlier?

(q) The earlier the intervention the easier it is to reverse the specific abusing behavior.

(r) When students have exhibited a negative attitude toward school and receive group and individual counseling which focuses on student's individual responsibilities there is a significent positive change in their attitudes towards school teachers and administrators.

(s) Since ten out of twenty students improved in five or more behaviors, we may conclude that once one negative behavior is identified and intervention is provided there is a positive ripple effect on other acting-out behaviors.

(t) Where you have an alcoholic parent along with other indicators, it is more likely that a child will exhibit negative acting-out behaviors.

(u) Once the program is implemented in a particular school it is seen by the school's principal as worthy of continuing each year.

(v) The validity of a longitudinal study is affected by the limitations of staff time since all other regular services must be maintained.

IMPLICATIONS OF FINDINGS AND CONCLUSIONS FOR THE SUBSTANCE ABUSE TREATMENT FIELD

Of the specific group cited in this paper, six of the students did not become drug abusers. Two students are currently abusing drugs - of the two, one was referred to Daytop Village Inc. but the parents refused the referral, and the other was placed in Special Education, as a result of the parents' uncooperativeness. Two of the students left the system after the first year of their participation in the Self Awareness Center. One students was placed in Special Education (Class for the emotionally hadicapped), and we lost contact with the child and family.

At a critical time in the child's life - early adolescence (ages 11-15) - children who exhibited all the symptoms of susceptability to drug usage, i.e. poor self-image, angry, irresponsible, negative attitude towards authority figures, alcoholic or substance abusing parent or close relative, hostility, single parent or in the process of a divorce half of the students given intervention services during this time did not choose the drug scene. Quite the opposite, they improved in self image, made successful adjustments and progress academically, socially and within the family.

The results of the group discussed herein are typical of our experiences and results with all of the groups who have participated in the Self Awareness Center.

Therefore, by focusing on the symptoms and the related acting out behaviors prior to the onset of drug abuse at a pre-adolescent stage, and maintaining contact with the child during the early adolescent years, in at least 50% of the cases, drug abuse was prevented.

This does not mean that treatment programs will no longer be needed or cease to exist. There will always be failures. The human relations field had never been 100% efficient. We will always have parents who refuse to accept early diagnostic findings or referrals, or who choose an easier way out such as incorrect placement in Special Education Programs.

In addition, each child's need differed in accordance with his/her individual developmental stage and in relationship to the current conditions within the family. One might conclude that, at least for the adolescent substance abuser, there is a need for the individualized treatment plan.

We found that there is a direct correlation between the parents' involvement, reaction and/or response and the progress or regression of the child. This would highlight the absolute need for parent programs in adolescent treatment programs. Parent programs that focus on parenting skills, limit setting skills, communication skills, problem solving skills which is different from most parent programs which exist in therapeutic programs today. Therapeutic parent programs provide orientation sessions for the parent to learn about the program, how to communitcate to staff for the purpose of providing feedback, provide pre-confrontation sessions to prepare the parent for participation in the confrontation group where the parent will focus on his or her or their problems. The responsibility of the parent for the child is taken from the parent and given to the therapeutic program. It then becomes extremely difficult to return that responsibility to the parent at the end of the child's treatment. The problem is entirely different when dealing with adults in treatment and their families. One is more often dealing with the parents' guilt than parenting skills.

Academic achievement improved in every case where other behaviors improved without any tutoring services being provided. One might conclude then that the need to focus on educational services when treating the substance abuser does not exist. It is only in the mind of the helping person. When education is emphasized or prioritized over treatment issues, the entire process is clouded.

Most of the students in the Self Awareness Center were functioning above grade in Reading and in Mathematics. We know from our ecperiences of working with junior high school substance abusers, that if intervention is delayed, Reading and Math grades decrease as the level of dysfunction increases.

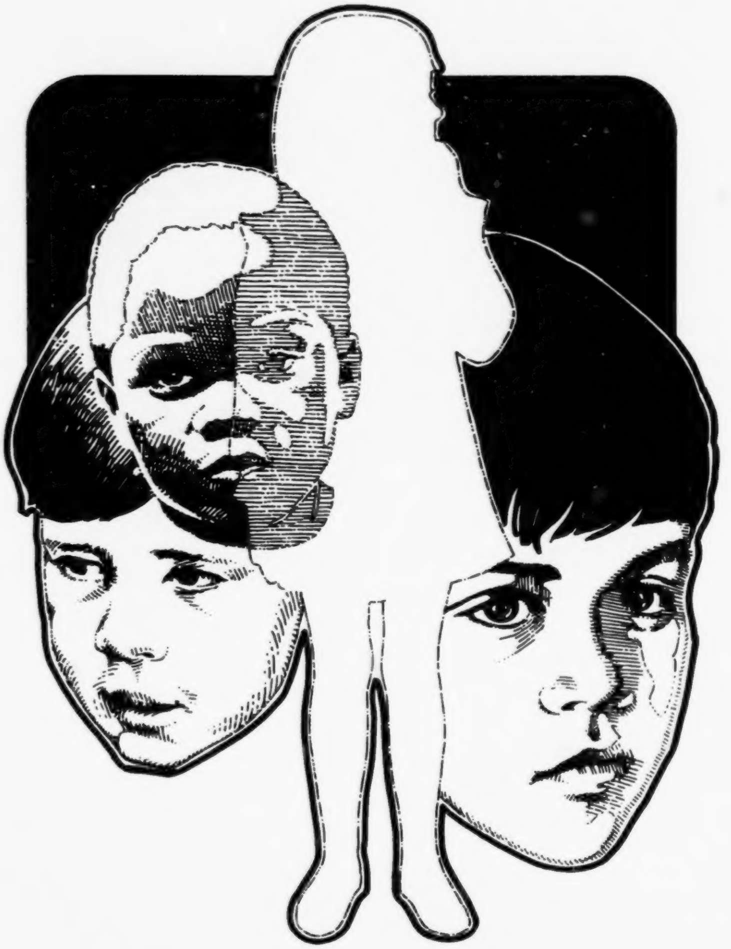
In this early indentification and intervention program, there are three males to every female who fit the criteria for the Self Awareness Center which is a combination of two or more of the following: Substance abusing/alcoholic parent, ex-offender parent, single parent, recent family crisis i.e. separation, divorce, serious illness, death, remarriage of parent, truancy, excessive lateness, Negative acting-out behavior, holdover, poor self-image, hostility toward authority, and withdrawn.

This is comparable to the population in treatment programs. There is no evidence of boredom and/or anomie among the 6th grade students. All research in substance abuse indicated that one of the primary causes of adolescent substance abuse is boredom, particularly at ages 13, 14 and 15. This boredom progresses to anomie at ages 15, 16, 17 and 18. The substance abuse problem progresses in incidence, variety and intensity with the chronological age. It would therefore seem appropriate that the best possible point of diagnosis and intervention might be at 6th grade. Motivation to change behavior and attitudes becomes more difficult as boredom and anomie increase.

Consequently treatment programs might explore the issue of advocacy for meaningful early indentification and intervention services and for research of these programs including longitudinal studies. If we are ever going to break the cycle of addiction and decrease the numbers of those in need of treatment or rather have treatment available for all of those in need of it, then we must focus on prevention. That does not mean that treatment programs have to provide the prevention but it does mean that networks between treatment and prevention programs are essential.

Since 50% of the students in the overall Self Awareness Center Program (125) improved in five or more behaviors and we concluded that once one negative behavior is identified and intervention is provided, there is a positive ripple effect on other acting out behaviors, then perhaps therapeutic communities might want to reasearch prioritizing behaviors or attitudes because some of the behaviors might be easier to change than others or have more of a ripple effect on other behaviors.

Programs for children of substance abusers are vital. They need not be provided by the treatment program but may be offered "in school". Furthermore, given the possibility of a genetic factor for a predisposition for substance abuse (as had been indentified by the alcohol field) there may be a need for early indentification and intervention programs for children of substance abusers regardless of the length of time they have been rehabilitated.



AN EXPLORATORY STUDY OF SCHOOL AFFECT OF ADOLESCENT LEARNERS IN A RESIDENTIAL TC

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Although treatment in a therapeutic community focuses primarily on clinical aspects of behavior, schooling, education and learning has become an increasingly more important part of the learning milieu. (Kajadan and Senay, 1976). Many studies have cited the importance of education in a therapeutic setting thus demonstrating the logical interface of clinical and educational components (Levant 1974, Biase 1983, and Biase and Sullivan, 1984). An ever growing number of youngsters in need of treatment for substance abuse and a high school education (Johnson 1984, Silverstein and Derivan, 1984) only underscores the need for a greater understanding of the part therapy plays in the schooling process. Both educators and mental health professionals support the notion that education may be a vehicle for creating integration of ideas, goals and clarification of values (Allinsmith and Goethal, 1972) note that the purpose of learning is not merely quantitative accumulative facts, but is instead an active cognitive construction and transference of reality. In summary, both mental health professionals and educators view learning from an ubiquitous base, nourished by a healthy self concept. Moreover, earlier studies of adolescent populations in the therapeutic setting report youngsters with poor attention span, fear of competition punctuated by high anxiety, lack of school success, corrosive family ç relationships illustrating the fundamental need to understand the total process of therapy and schooling (Bookbinder, 1975).

Therefore, the purpose of this paper, then, is to investigate the attitudes, feelings, self concept (school affect) of adolescent learners receiving their high school education within a residential therapeutic community.

Method

An original focused interview instrument was created to provide a frame of reference for the subjects' responses. The questions were designed to provide data on school affect (attitude toward academic subjects, school personnel, self concept as a learner in the school context, and the role of therapy in the schooling process. Questions were divided into five groupings: namely, (1) general feelings of self perception as a learner; (2) feelings related to curriculum/preference for academic subjects; (3) feelings related to teachers and other school personnel; (4) self perception as a learner in the therapeutic context; (5) the role of therapy in the schooling process.

Three groups of six, 18 subjects, were randomly selected from a pool of adolescent learners who had received treatment from zero to twelve or more months. Group one is described as young learners and received therapy zero to four months. Group two is described as advancing learners and received treatment five to eight months. Group three is described as mature learners and received treatment nine to twelve months. All of the subjects received their high school education within the residential facility.

The subjects were asked to respond to five open-ended questions during a face-to-face interview. An audio tape recorder registered all that was said during the interview. The interview was conducted at a leisurely pace. Each protocol was typed from the audio tape recording that was made during the interview session. Coders read the interview transcripts line by line. Any item of information in response to a question that could be construed as a descriptor, a concern, or an issue was abstracted onto separate 3 x 5 file cards. Different color cards were used to distinguish each category. The cards were cross referenced to the interview transcripts so that the context of the item could be reassessed when necessary. No attempts were made to eliminate items, inclusiveness rather than exclusiveness was sought.

In order to determine emerging categories, the coder sorted the cards into look alike piles according to similar responses. The first card automatically formed a category in response to the question. Then, the second card was assessed to differentiate it from the first. If it was different, it became a new pile. The process was repeated until cards were exhausted. Cards that did not seem to fit into existing piles were put into a provisional category.

The coder gave a title or name to each pile. Categories that were similar were subsumed under one of the major groupings (Guba and Lincoln, 1983). The coder assessed the provisional categories which emerged. Coders who did not take part in the actual data collection were used to analyze the data. Inter-rater reliability was established by computing the percentage of agreement between coders.

The following instrument was administered to adolescent subjects at a rural residential therapeutic community.

School Affect

(1) Academic self esteem/perception of self as a learner.

Do you think you are a good learner? Probe: Do you see yourself as a successful student? Why?

(2) Feelings related to curriculum/preference for subjects.

Do you have any school subjects that you enjoy? Why do you like that subject? Probe: Some people have good feelings about particular school subjects. Which subject is your favorite school subject? Do you have any school subjects that you dislike? Why do you dislike that subject? Probe: Some people have feelings connected with certain school subjects. Which subject do you dislike?

(3) Feelings related to teachers.

Did you ever have a teacher you liked a lot? Why do you suppose you liked that teacher? Probe: Some teachers and other people in school we like better than others. Tell me about your favorite teachers and why you liked this teacher. Did you ever have a teacher you really disliked? Why do you suppose you disliked that teacher? Probe: Some teachers and other people in school we like better than others. Tell me about the teacher you disliked the most.

(4) Self perception of learner in the therapeutic context.

Now that you are in treatment, do you see yourself as a successful learner? Probe: Do you see yourself as a person who can succeed in school now that you are in treatment?

(5) The role of therapy in the schooling process.

Is there anything that you can take away from treatment to school? Probe: Do you think there is anything that you learn in treatment that helps you in school?

Results

In this study, the verbal reports generated by the focused interview caused the subjects to render a large quantity of data and numerous pages of transcripts. All audio tapes were transcribed and then coded. In order to present data in a manageable format, the results are reported by directly addressing each of the research questions listed below:

1) How does time in therapy affect academic self esteem (self perception of learner and student) in young, advancing and mature learners?

2) How does time in therapy affect attitude toward curriculum/preference for academic subjects in young, advancing and mature learners?

3) How does time in therapy affect attitudes toward school personnel (teacher/principal)?

4) How does time in therapy affect perception of learning in the therapeutic context?

5) What is the role of therapy in modifying or changing the schooling process?

Frequency summaries were made of emerging categories and the number of responses made in each category. Ipsative analyses were made to describe the qualitative differences between subjects.

1) How does time in therapy affect academic self esteem (perception of self as a learner and student) in the young, advancing and mature learners? As shown on table 1, salient patterns of responses appear to emerge. Young, advancing and mature learners appear to express doubt in regard to their self image as a learner and student. Many stated, "I could learn if I really wanted to learn." Others merely state that they could learn if they pushed themselves. Similar responses emerged across groups.

2) How does time in therapy affect attitude toward curriculum (favorite subject, disliked subject) in young, advancing and mature learners? Table 2 shows that subjects in all groups appear to choose reading as their favorite subject and mathematics as the subject they dislike the most. This pattern appears to emerge across groups.

3) How does time in therapy affect attitudes toward school personnel (teacher/principal) in the young, advancing and mature learner? Young learners explained that their favorite teacher was "funny" or didn't yell. Advancing learners described their favorite teacher as one who had a sense of humor, others said, "My favorite teacher made me feel good about myself, cared about me, and I felt I could talk to the teacher." Mature learners described their favorite teacher as one who showed, "love, concern, made me feel good about myself." The negative probe or most disliked teacher probe elicited responses that were dissimilar. Young learners described their most disliked teacher as one who yells a lot or does not explain things. Advancing learners stated that the teacher they disliked the most made them feel bad about themselves. The mature

learners characterized the teacher they disliked the most as one who did not show "concern and didn't care about them as human being." One subject noted, "Mr. X just couldn't communicate with me."

4) How does time in treatment affect perception of schooling, education and learning in the therapeutic context? Young learners described schooling and said that the teacher has more patience, the school has smaller classes. Advancing learners viewed schooling from a different perspective and focused on the difference in their fellow students' behaviors and attitudes, i.e. "Kids are different; we help one another and I feel I am not alone." Another subject stated that other students showed concern. Mature learners described schooling in the therapeutic context as, "A place where the teacher is a friend, father-mother figure, a helper," as shown on table 4. These learners also reported that school is a place to plan for the future and a place where "I don't give up on self."

5) What role does therapy play in the schooling process? Young learners viewed school and therapy as two separate parts of their lives, although one subject stated that therapy "raises levels of awareness." Advancing learners remarked that therapy made them "look at themselves and things they needed to learn." Mature learners viewed school and therapy as interactive modalities. Mature learners suggested that they carried ideas from therapy to school. One subject stated, "People can learn who they are and want to be." Another subject said, "Before I used to give up on myself, but not now!" Another subject noted, "Learning changed my life!"

Emerging patterns related to most disliked academic subject indicates that learners dislike subjects with structure and self discipline. Youngsters expressed dislike for mathematics, which is a highly structured and sequential subject discipline. This pattern emerged across all three groups and it may indicate that these learners lack prequisite skills for mastery of mathematics and fear repeated failure. Additionally, the hierarchial process in treatment is revealed in the affective relationship and quality of academic preference.

Emerging patterns related to attitude toward school personnel and preference for teacher suggest that as learners progressed with therapy they began to appreciate the role of teacher as facilitator of learning. Young learners judged teachers in a superficial manner and said that they preferred teachers who were funny or did not yell. Emerging patterns of advancing learners reveal a continued narcissism. These learners viewed the teacher as one who provided learning for them. This group failed to recognize their role in the learning partnership. Mature learners spoke of interpersonal relationships with their teacher. These learners appeared to be standing back from the classroom scene and stating that they liked teachers who cared for them as human being and motivated them to be motivated. Mature learners appreciated supportive educators and indicated that they had succeeded in assuming responsibility for their own learning.

Advancing and mature learners responded to probes related to school in the therapeutic setting by describing school as a place where there is love and concern. The patent implication may be that as youngsters spend more time in treatment they incorporate these ideas into every aspect of their existence and are then able to translate these therapeutic concepts into modes of self actualization. Clearly, learners who had been in treatment longer indicated that they viewed the teacher as a motivating source, a facilitator of learning, and that school was the focal point for making a future. Young learners failed to make a connection between school and therapy, while advancing learners indicated an appreciation for school which they attributed to treatment. These learners were able to articulate a "world view."

Another aspect revealed in the investigation may be the Yin and Yang idea, the simultaneous growing of one self by helping others to grow. This is suggested by references to peer involvement and tutoring and helping within the context of the lesson. Learners take ownership for their feeling and learning experience.

Summary and Conclusions

Clearly, this exploratory study presents preliminary findings.Small groups of subjects were used. It is a truism that these findings cannot be generalized to a target population. However, the nature of this research should not negate the importance of the data. Naturalistic research has as its goal the development of working hypotheses, rather than a priori testing of hypotheses. Guba and Lincoln (1981) suggest establishing a degree of structural corroboration by cross-checking different data sources through triangulation or combination of multiple investigations. Therefore, we contend that as statistical means are more stable than single scores, so triangulated conclusions are more stable than single scores, so triangulated conclusions are more stable than any of the individual vantage points from which they were triangulated. It then follows that this exploratory study should be followed by other instrumentation. Other investigations should be done in order to çverify working hypotheses, to clarify, extend or modify the result of this current study.

Patterning does occur across groups. Youngsters in all three groups appear to have doubts about themselves as learners but seem to express their reservations with different rhetoric. Differences in responses occur when youngsters in advancing and mature learners groups characterize their most favorite and disliked teachers. Salient issues emerge, the youngsters appear to respond on three levels. These subjects demonstrate differing levels of awareness. Young learners indicated that they were going to maintain a safe position--they were not going to engage in risk taking. Advancing learners maintained their

TABLE 1 Emerging Categories and Number of Responses Related to Academic Self Esteem (Perception of Self as Learner)

Group	Emerging Categories		
Young	I can learn when I feel like it. 4	I think so, yes, maybe 1	I don t know, was getting high 1
Advancing	I could if I pushed myself 4	Yes, now I can but not before 2	
Mature	Yes, I am certain 4	I can --sometimes I do get lazy 2	

TABLE 2 Emerging Categories and Number of Responses Related to Curriculum (Preference for Academic Subjects)

Group	Categories			
	Favorite Subject		Disliked Subject	
Young	Reading 4		Math 2	
Advancing	Reading 4		Math 1	Social Studies 1
Mature	Reading 5	Science 1	Math 5	Science 1

TABLE 3. Emerging Categories and Number of Responses Related to Attitude Toward School Personnel (Preference for Teacher).

Group	Emerging Categories				
	Favorite Teacher		Disliked Teacher		
Young	funny 4	does not yell 2	mean 4	yells 2	
Adv	Made me feel good about myself 2	Made me feel Special 4	Made me feel stupid 2	Really didn t care 4	
Mature	would really listen 4	Supportative 2	No personality 1	wasn t role model 1	Couldn t relate 4

TABLE 4. Emerging Categories and Number of Responses Related to School in the Therapeutic Context

Group	Emerging Categories			
Young	School is no different 1	Teachers are friendly 3	Smaller classes 2	
Adv.	Can learn better 1	Encourages me to try to learn 2	Helps me plan for the me plan for my future 1	I don t give up on myself 2
Mature	really pushes the motivation issue	motivated to be motivated	teacher is a helper, mother, father figure	

TABLE 5. Emerging Categories and Number of Responses Related to the Role of Therapy in the Schooling Process

Group	Emerging Categories			
Young	Learning to deal with things 2	people have time for one another 2	Raises levels of awareness 2	
Adv.	Makes school more important 1	I don t give up on myself 4	Makes me think about my future 1	
Mature	Makes me more responsible 2	Makes me look at who I am 1	Puts pressure on me 1	Helps me see my potential 1

safe position and put the issue of responsibility under the teacher's control while nature learners indicated that they had a greater willingness to accept the responsibility for their education. These previously cited learners also indicated a higher level of risk taking and greater self confidence. Emerging patterns across all three groups related to attitude toward curriculum or preference for academic subjects appear to indicate that learners favor unstructured self absorption in their choice of reading. All groups indicated that reading enhanced their daily existence and it was something they could do alone. In short, it could be done in isolation.

A final issue should be the overall educational ramifications of therapeutic intervention on self esteem and self concept. Some educators have been preoccupied with awesome heights of scholarship, therefore causing an emotional toll and scar tissue on the learner. In many instances, this scar tissue has had profound effects on youngsters, and this problem seems to have gone un-corrected. It is possible that therapeutic intervention makes schooling a constructive rather than destructive experience. The therapeutic community may recognize the true spirit of schooling, education and learning (Silverstein, 1983). Ralph Tyler (1976, p. 56), a distinguished educator, noted: "It is my belief--certainly that is not held alone--that the proper function of schooling ought to be that of making human beings better." In the same spirit Albert Einstein noted that, "knowledge is dead; the school, however, serves the living. It should develop in the young individual those qualities and capabilities which are valued for the welfare of the commonwealth." He then added, "...the aim must be the training of independent acting and thinking individuals who, however, see in the service of the community their highest life problem." Perhaps the final proof of the supposition that the therapeutic community's approach to learning and schooling is credible may be found in a description of Daytop Village, a highly regarded East Coast therapeutic community. Visiting Daytop Village Maslow noted,

> And this brings out the idea of education, and of Daytop as an educational institution. It is an oasis, a little society which supplies the things all societies should supply but don't. In the long run, Daytop brings up the whole question of education and the use which cultures make of it. Education does not mean just books and words. The lessons of Daytop are for education in the larger sense of learning how to become a good adult human being. (Maslow, 1971, p. 220)

It is our contention that the therapeutic community is a learning environment which serves as a change agent. In this institution, the role of schooling plays a significant part to the greater end. Learning and schooling are viewed as an interactive partnership and schooling is an integral part of the self actualizing process.

In summary, there is a cogent need for more and varied research. There is a need for naturalistic process studies, ethnographic investigations, single case studies of behavior, interview and observation research. Clearly, continued investigation of the role of the therapeutic community in the schooling process will add to the body of research on school affect and self concept.

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THE REVOLUTION OF THE RESPONSIBLE ROLE MODEL

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John Dewey's Educational Thought: Its Relevance to the 21st Century

Dewey was influenced by the times when he lived. He wrote about "new education" during the 1890's but was influenced by the works of Rousseau (1768), Pestalozzi (1827), and Herbart (1901). Even though Dewey formulated most of his educational philosophy before the impact of the Industrial Revolution had been experienced, his beliefs remain remarkable contemporary. The authors have no vested interest in attempting to resurrect Dewey but do so only because his progressive ideas may be more relevant today than ironically when the philosopher-psychologist-educator wrote. Dewey died before the advent of the nuclear age and the invention of the computer which has transformed society and education. Neither the past nor the future can be ignored because to stay relevant, education must continually change. We use Dewey as a point of departure only because many of his concepts have vitality today. We use Dewey because to deny his existence and subsequent impact on education would be to acknowledge our ignorance. Our humility and sense of scholarship compels us to re-read Dewey because we do not wish to re-invent the wheel.

Dewey (1899) proclaimed; education is experience; it is growth. Actually, the educative process is an interaction between experience and growth which becomes what Dewey (1936) has termed "self-renewing." Undeniably, the singular aspect in the spectra of human beings is the capacity for growth. To be alive educationally suggests growth; when individuals stagnate conversely they cease to learn. Hence for Dewey the optimal concern of education involved experience which produces catalytic growth necessary for learning. Dewey (1902) has identified three kinds of growth which encompass learning -- i.e., intellectual, emotional, and moral. To this end, the John Dewey Academy believes that the social, cognitive, creative, ethical and academic development of the student is enhanced when the individual is expected:

- to develop a positive concept of self and a proactive philosophy of life;
- to assume responsibility for one's behavior and recognize that constructive change is possible;
- to formulate intermediate and long term goals;
- to be aware of meaningful rewards for productive behavior and tangible consequences for irresponsible acts;
- to learn how to use, rather than continue to abuse, his or her potential and talents;
- to understand one's role in society and to contribute creatively to its betterment;
- to love and be loved, to trust and be trusted, to respect and be respected, and to help and be helped;
- to work with teachers who genuinely care and sincerely believe each student is capable of improving his or her academic performance;
- to want to learn and to improve one's self;
- to become involved in a rigorous learning process and to determine to some extent what is important to learn;
- to think abstractly and to problem solve;
- to achieve written and verbal communication competences;
- to attain mathematical and computational competences; and
- to appreciate intellectual, cultural and artistic achievement.

In order for education to be meaningful, it must include more than academic material. Recognizing this reality, Torrey (1974), a psychiatrist, pleads for the incorporation of relevant humanistic reform which requires the study of human behavior as it related to a comprehension of the student's behavior and the motivation of others:

> The consequences of omitting the study of human behavior from education have been devastating. They are seen in the banality and triviality of its curriculum. They may also be seen in the revolt of contemporary students against it. No longer content to accept tradition as the guide, increasing numbers of students are asking for an education which has both social and individual relevance. They want to know why people behave as they do -- both themselves and others -- and what the alternatives are.

A former student of Dewey who became a distinguished professor of philosophy, Hook (1956), believes that his mentor will be:

> Regarded as the philosopher of human growth in the age of modern science and technology, and the philosopher who saw man not as a creature with a fixed nature, whether conceived as a fallen soul or a souless configuration of atoms, but as developing mind-body with an historical career, who, because he does something in and to the world, enjoys some degree of freedom, produces consequences never witnessed before, and leaves the world different from the world into which he was born.

Dewey was explicit. The task of education is not to provide students with an abundance of information because the possession of knowledge must not be viewed as an end in itself. Education, to be effective, must become a way of living that stimulates and inspires learning by active effort as naturally as does education outside the formal confines of the classroom. Otherwise intellectual, emotional, and moral growth that involve the total growth of individuals will not occur. Most assuredly only when the individual is viewed as a living organism who has the capacity for rational thought but is nurtured by emotion can profound pragmatic education take place. The most meaningful aspect of education is that it helps the individual not only become more aware of the conditions that product growth, but also helps him/her to profit from experience. Usually the attitude developed in the process of learning becomes more crucial than the actual information acquired. The ultimate educational goal is to motivate students to want to continue to learn for the idealistic sake of learning so they can improve themselves and shatter the relatively restricting parameters of ignorance.

Tragically, much of the confusion and controversy which obfuscates Dewey's educational theory results from ignorance. Crosser (1955) and many others obviously do not understand Dewey's progressive education is that he anticipated the revolt against the sterility of the curricula. Nowhere does Dewey infer that disciplines such as grammar, arithmetic, geometry, astronomy, and the study of classical languages which involve rote learning and memorization be deleted from the curriculum. Quite to the contrary, Dewey recognized and appreciated the importance of informed awareness of facts and problems. Dewey recognized the numerous contributions which science and technology have made to the betterment of life. Dewey certainly would have endorsed Bernstein's plea to include science in the curriculum. Bernstein (1982), in fact, writes:

> We live in a complex, dangerous and fascinating world. Science has played a role in creating the dangers, and one hopes that it will aid in creating ways of dealing with these dangers. But most of these problems cannot, and will not, be dealt with by scientists alone. We need all the help we can get, and this help has got to come from a scientifically literate general public. Ignorance of science and technology is becoming the ultimate self-indulgent luxury.

Dewey did protest against knowledge and scientific discovery without seeking to show its relevance and relatedness to important personal and social concerns. To this end, pragmatic education needs to prepare students to anticipate and adapt to the future. No longer are teachers custodians for the past. In Toller's (1974) important compendium about futology Buchen (1974) contends:

> Futurism...provides an excellent academic opportunity to test a student's true knowledge of what he has learned, for example, of the principles of sociology or economics, by asking him or her to design a new social institution or some new aspect of an economic system. Both history and futurism can be honored by reconvening the first Continental Assembly and drafting anew a portion of the Constitution..

But to accomplish these crucial educational tasks, there is an undeniable need to subject students to some trivium and quadrivium. The actual learning of the facts may be boring, but are necessary before informed decisions can be made. Dewey protested against a sterile curricula divorced from interest and value. Rogers (1961) has placed Dewey's concerns into perspective when de defines significant learning:

> By significant learning I mean learning which is more than an accumulation of facts. It is learning which makes a difference -- in the individual's behavior, in the course of action he chooses in the future, in his attitudes and in his personality. It is a pervasive learning which is not just accretion of knowledge, but which interpenetrates with every portion of his existence.

Recognizing the importance of education, in general, and the role of the teacher, in specific, Hook (1946) confirms that, "The function of the teacher is among the most important in our culture. He not only transmits essential knowledge and skills but, when he takes his call seriously, strongly influences the formation of habits and development of a philosophy of life." Postman and Weingartner suggest that the teacher's task is to stimulate inquiry. Students need to learn how to examine and then deduce the truth. Using provocative rhetoric, Postman and Weingartner (1969) define the educational goal, "to help all students develop built-in, shockproof crap detectors as basic equipment in their survival kits." Writing half a decade later, Griffith (1974) points to the obsolesence of Postman and Weingartner's thinking when she contends: "Yet the student needs more than a crap detector. He also needs a gyroscope. He must be able to act -- to adapt to change, to be a viable human being while undergoing a severe form of cultural stress, future shock."

Pragmatic education, according to Dewey, helps students grow itellectually to develop a positive philosophy of life, grow emotionally to become a responsible adult, grow morally to achieve a sense of integrity and decency. Dewey believed that the teacher's contribution to this growth triad was to be the overseer and facilitator. If we agree with this conceptualization, then we must examine specifically the educator's role in and contribution to the teaching-growing-learning process.

The Educator as a Responsible Role Model: The Crucial Ingredient to the Teaching Relationship

Despite Pestalozzi's (1827) and Dewey's (1897 and 1916) conclusion that the pedagogical relationship is synonymous with education, educators have been reluctant to modify the traditional authoritarian teaching concept which resembles the medical model. The doctor is seen as the expert and presumably to be healthy while the patient, in contrast, is ignorant and sick. By virtue of being placed in a position of superiority, furthermore, the physician prescribes and the patient is expected to conform. Bratter (1976) has condemned the misuse of the power which teachers can apply to ensure conformity when he writes, "Teachers, in addition, arm themselves with some necessary weapons to ensure sameness and conformity to the norm. They have the awesome power to label a person an 'A', 'B', 'C', 'C', or 'F'. Sometimes to be more scientific, a specific grade is assigned -- 98, 87, 76, 65..." The care-custody-control atmosphere can produce conformity which is anathema to the Rogerian concept of significant learning. Until educators begin to accept Barzun's (a colleague of Dewey's) definition of a good teacher, they will not modify the repressive traditional teaching model. More specifically, Barzun (1945) writes: "Consequently, the whole aim of good teaching is to turn the young learner, by nature a little copycat, into an independent, self-propelling creature, who cannot merely learn but study -- that is, work as his own boss to the limit of his powers." This is to turn pupils into students. No longer can educators afford to assume that their students want to learn for the sake of learning.

Before any meaningful learning can occur, the teacher must convince students that he or she merits their respect and trust. The human element, the charisma, indeed, the personality of the teacher becomes crucial. The pedagogical relationship becomes the foundation for any theory of education. Buber (1955 and 1958) has described the pedagogical I-Thou relationship as a special one, but does not discuss the aspect of the responsible role model which is predicated upon reciprocity and transparency. When prescribing future educational reform, Eurich (1974) proposes a radical modification of how teachers relate not only to students but also subject matter:

> We first need teachers and scholars eager to tear off their protective masks and engage personally with their materials -- people willing to say "I believe," or "I think," and take strong positions on whatever issue or question is at stake. While objectivity and critical inquiry are essential, they can no longer be tolerated as a shield against commitment; neither approach is exclusive of the other.

Eurich is correct in her assessment. Students, indeed, have a right to know what the teacher believes so they can place in perspective the mentor's biases to determine for themselves "truth." Unless the teacher abandons the more secure, hence more obscure, neutral position and becomes passionate and animated, students simply will "turn off and tune out" because they will lost interest.

The justification for teaching transparency and vulnerability is offered by Glasser, a psychiatrist, who has worked extensively with educators. Glasser urges therapists to become more involved with patients by becoming more personal and friendly. Though Glasser (1965) describes the personal attributes for therapists to acquire, certainly he would apply the same criteria for effective teachers:

> The therapist must be a very responsible person -- tough, interested, human, and sensitive. He must be able to fulfill his own needs and must be willing to discuss some of his own struggles so that the patient can see that acting responsibly is possible though sometimes difficult. Neither aloof, superior, nor sacrosanct, he must never imply that what he does, what he stands for, or what he values is unimportant. He must have the strength to become involved, to have his values tested by the patient, and to withstand intense criticism by the person he is trying to help. Every fault and defect may be picked apart by the patient. Willing to admit that, like the patient, he is far from perfect, the therapist must nevertheless show that a person can act responsibly even if it takes great effort.

While Glasser's thesis that the helping individual becomes a responsible role model appears logical and simplistic, tragically it is revolutionary. Freud (1912) urged the psychoanalyst to "put aside all his feelings and stated that "the doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him." This position of the detached observer has been repeated ad infinitum by the most respected psychoanalytic practitioners. Szasz (1965) urges psychoanalysts "not to show that you are humane, that you care for him (the patient)...Your sole responsibility to the patient is to analyze him."

A young psychoanalyst confesses his ambivalence regarding his adherence to the code of anonymity. An anxious homosexual patient feared that the analyst was attempting to seduce him. Rather than proclaim his heterosexuality, the doctor instead elected to analyze the patient's fears. Not receiving any reassurances from the analyst, the patient became so agitated that he contemplated terminating therapy. While becoming so anxious during one session, the patient nervously opened a little box on the therapist's desk. Glazer (1981) reports, "I clearly remember his smiling and visibly relaxing. Examining the box after the session revealed a love note to me from by fiance, from whom it had been a gift. I had never looked inside." The temptation if too great not to editorialize by rhetorically asking "Is this typical psychoanalytic behavior, not to invest enough of one's self to open a box to peer inside knowing it is a present from your fiance? While Glazer realizes that, "My unintentional self-disclosure had facilitated the process," he is not convinced it is justified.

To its credit, Alcoholics Anonymous (1939 and 1952) recognizes the effectiveness of utilizing recovered persons to function as responsible role models to produce positive therapeutic change. The American self-help therapeutic community, as described by Bratter (1978 and 1985), has adopted with much success the model of the responsible role model as the primary treatment agent. Bratter (1977), in fact, writes: "The staff function as responsible role models who are living proof that creative and constructive personal change is possible." In addition, the staff is prepared to share significant experiences in an effort to identify with and relate to the resident. The staff becomes involved with the resident. credentialed professionals, in contrast, have been trained to treat symptoms, not to identify with the patient.

Children and adolescents, in part, gain their unique identities when they interact with others. The teacher needs to understand this crucial dynamic because it has profound implications for pedagogy. Simply states, there is a dearth of positive adult role models. The 1960's and 1970's witnessed the demise of the nuclear family. Grandparents no longer remained in the house. They elected to migrate to Florida, live in century villages, or else have been shipped to nursing homes. Families have been forced to re-locate as job demands required mobility. Some parents often are forced to work more than one job just to maintain, not improve, the quality of life. Others are forced to commit themselves totally to work so they are rendered virtually absentee because they are required to work long hours or travel extensively, so when they return home they are too drained from the demands of the job to be able to relate to family members. Adolescents discover there are few positive adult role models with whom they can identify. There is a sense of desperation, of insecurity, and frustration that causes adolescents to seek the authoritative adult source of wisdom, the Supreme Being, for security and mission. Wolfe (1936), the American novelist, recognized this need and cogently has summarized this pervasive search when he writes:

> The deepest search in life...the thing that in one way or another was central to all living was man's search to find a father, not merely the father of his flesh, not merely the lost father of his youth, but the image of a strength and wisdom external to his need and superior to his hunger, to which the belief and power of his own life could be united.

By virtue of the amount of time spent with students and frequent interactions, the teacher functions as a responsible role model. Adolescents unwittingly scrutinize and incorporate many of the educator's implicit beliefs and values. It is precisely in this realm that the caring and dedicated teacher must accept not only the challenges of providing a pragmatic education, but also the awesome responsibility of permitting him or herself to become a role model. Like it or not, the teacher by some sort of insidious default has become the parental surrogate. Perhaps, because the majority of teachers was unaware or maybe unwilling to assume this crucial developmental role during the late 1970's and early 1980's, as Bratter (1979) discusses, the educator became the enemy of the people. Adolescents derive a significant part of their personal identities by constant interaction with the teacher who transmits the values of society. Boyer (1983) is aware of the acquisition of personal identities and social integrity when he describes the characteristics of an effective mentor which include more human qualities than former times:

> There remain some old-fashioned yet enduring qualities in human relationships that still work -- command of the material to be taught, contagious enthusiasm for the work to be done, optimism about the potential of the students..., and human sensitivity, that is, integrity and warmth as a human being. When we think of a great teacher, most often we remember a person whose technical skills were matched by the qualities we associate with a good and trusted friend..

In her portraiture of "goodness" in six high schools, Lightfoot adds another crucial dimension to her description of a good teacher which is an intensely human quality. Lightfoot (1983) defines empathy as:

> ...the ability to place oneself in another's position and vicariously experience what he is feeling and thinking. The empathetic stance is a crucial ingredient of successful interactions between teachers and students. Empathy is not adversarial; it does not accentuate distinctions of power; and it seems to be an expression of fearlessness. By empathy, I do not mean something sentimental and soft. As a matter of fact, the empathetic regard of students is often communicated through tough teacher criticism, admonitions, and even punishment.

A component of empathy must be awareness of the continual societal changes and pressures which affect the individual. Before the 20th century, individuals essentially struggled to survive against the hostile environment and natural forces beyond their control. The individual's self-worth was determined by the personal goals attained. The role of the worker was the primary source of status and gratification. More recently however, there has been a significant shift. While survival remains primary, the battle no longer is against nature but instead desperately focuses on how to control lethal human created weapons which have the potential to produce mass annihilation of staggering proportions. In an important book which documents the individual's quest to gain acceptance as a person rather than a performer, Glasser (1972) reminds us:

> Led by the young, the half-billion people of the Western world have begun a rapid turmoil-filled evolution toward a new role- dominated society, the civilized identity society. Less anxious about fulfilling goals to obtain security within the power hierarchy, people today concern themselves more and more with an independent role -- their identity. Arising from our need for involvement, identity or role is either totally independent of goal or, if goal is role related, role is more important. Of course, people still strive for goals;

> increasingly, however, they are goals, vocational or avocational, that people believe will reinforce their independent human role, their identity. The goals may or may not lead to economic security, but they do give people verification of themselves as human beings. For example, not everyone can work at a job that supports his role, such as doctor, artist, or teacher, but anyone can pursue a recreational goal, such as bowling or playing bridge, or a volunteer goal such as working at a hospital or fund raising, that reinforces his independent role.

Both Boyer and Lightfoot reflect Glasser's observation because they believe the effective educator, in addition to being a teacher, must become a responsible role model. The additional challenge and burden added to teaching is the fact that the educator is a parental surrogate. Students demand to be seen as people rather than as pupils. Students, in addition, demand that the teacher become human rather than to remain an automaton who disseminates information. Teaching can be painful because adolescents have been ruthless in their criticism and hostility which periodically have been focused against the teacher who represents noxious and repressive authority. The teacher needs to understand that when he or she is prepared to relate honestly and humanly, students will begin to trust and respect. Both Boyer and Lightfoot would agree that the effective teacher must have the courage of his or her conviction and be able to communicate rationally personal beliefs. Perhaps, in the final analysis, maybe the keys to being a responsible role model are courage and personal integrity:

1) courage to be human, to risk and invest in students when they continually hurt and disappoint those who care for them;

2) courage to be innovative and creative to devise compelling strategies to compel students to want to learn;

3) courage to stand alone against the class and insist they perform to the best of their ability;

4) courage to continue to believe passionately that anyone can improve his or her performance rather than accept continued mediocrity or failure; and

5) courage to never give up knowing that each individual is capable of achieving success and becoming a worthwhile person by becoming more responsible, honest and decent.

Maintaining high expectations for improved behavior is a necessity for any responsible role model who demands the best not only for but also from him or herself. Shaw (1913) has written a fictionalized play, "Pygmalion," which describes the impact that high expectations of a mentor has on the student. One need only to read about the heroic efforts of Anne Sullivan to tame, harness and direct the incredible energy and talent of Helen Keller which has been portrayed by Keller (1955) as an autobiography, by Gidson (1960) as a play, and by Lash (1980) as a biography of both women. Surprisingly, not much has been written about the impact of the positive self-fulfilling educational prophecy which has been described by Rosenthal and Jacobson (1968) and Rosenthal (1973). Predictably, Thorndike (1968), Jensen (1969), and Wilkins (1977) have challenged the methodological design of Rosenthal's work. Meichenbaum and Smart (1971), who reinforce Rosenthal's works, suggest that, "The expectancy statements resulted in greater self-confidence, greater expectation of academic success."

It needs to be stressed that not every educator can or, in fact, should teach adolescents. Those who appear to be most effective possess a human quality which Tillich, a theologian, has defined as "caritas," which is a non-compromising and nonpossessive form of caring. Explicit is a toughness that each student is free to produce academic work of quality if only he or she will make the necessary investment. Glasser (1969) addresses this specific point when he suggests that adolescents need teachers "who will not excuse them when they fail their commitments, but who will work with them again and again as they commit and recommit until they finally learn to fulfill a commitment." The teacher unwittingly abets mediocrity and failure if he or she will accept excuses, no matter how valid and compelling, for a poor test performance or an assignment which does not reflect the best work the adolescent can produce. The effective teacher who serves as a responsible role model explicitly communicates a concern with the "bottom line," i.e., accountability and productivity, which is rewarded in the macrocosm. Demanding the very best from an individual is one of the primary ingredients of a caring relationship. Mayeroff (1971) writes, "To care for another person, in the most significant sense, is to help him grow and actualize himself." Fromm (1956) adds the crucial dimension of caring when he answers the rhetorical question he poses for readers to ponder:

> What does one person give to another? He gives of himself, of the most precious he has, he give of his life...he gives him of that which is alive in him; he gives him of his joy, of his interest, of his understanding, of his knowledge, of his humor, of his sadness -- of all expressions and manifestations of that which is alive in him. In thus giving of his life, he enriches the other person, he enhances the other's sense of aliveness by enhancing his own sense of aliveness. He does not give in order to receive; giving is in itself exquisite joy. But in giving he cannot help bringing something to life in the other person, and this which is brought to life reflects back to him; in truly giving, he cannot help receiving that which is given back to him. Giving implies to make the other person a giver also, and they both share in the joy of what they have brought to life. In the act of giving something is born, and both persons involved are grateful for the life that is born for both of them.

It becomes imperative for the responsible role model to have formulated his or her own stable and unique identity. The authenticity of the educator's persona can be assessed by students on the basis of interaction when the teacher displays his or her social integrity. There exists a vital correlation between the students' development of their ego identity and expressions of social integrity which Erikson (1968) has described. Fromm (1968) adds an important dimension when he suggests, "Integrity means a willingness not to violate one's identity." Erikson (1963) writes that children need to feel trust which can be nurtured with "the assured reliance on another's integrity." Students learn when there is a meaningful relatedness and respect between them and the teacher. Perhaps, the only way for the educator to achieve this meaningful relatedness is by functioning as a responsible role model which invariably thrusts the teacher into the charismatic role of parental surrogate who demands the very best from students. The teacher needs to be honest and transparent so that students can view him or her as a potential responsible role model; needs to be caring, optimistic, and passionate while concurrently being assertive, demanding and direct; needs to be definite by expressing personal values and opinions; and needs to be willing to develop a humanistic relationship predicated upon reciprocity, sharing and caring so students can have a meaningful dialogue and begin to develop their unique identities. This is the pedagogical relationship.

A Warning

Goodlad's (1983) sobering conclusion that "teachers are widely reported to be frustrated, burned out, uncertain as to what is expected of them and suffering from low morale" is a realistic appraisal of the current crisis which confronts education. Goodlad (1983) offers the reasonable explanation that "many of those persons coming into teaching today appear to be less well prepared intellectually and academically than their counterparts of an earlier time." The mistrust and disrespect for teachers both as technicians and persons is at its zenith. This has profound implications for the future of teaching. Kafka (1915) wrote a short story, "Metamorphosis," in which the protagonist who failed to actualize his humanness was turned into a cockroach. If teachers fail to become responsible role models who can inspire active and meaningful learning, they deserve to abdicate their profession. While some may dismiss Skinner (1984) as being too radical or cynical when he proposes that teaching machines can educate, they may underestimate the legitimacy of his concern. If teachers fail to teach, why not replace them with machines? The assembly line worker has been replaced by the robot. The elevator operator is extinct because elevators are not automated. Perhaps the classroom in the 21st century will have a teaching machine "lecturing" students. Teaching machines will be able to grade standardized tests objectively. Asimov (1960) philosophically ponders whether or not computers will replace persons in the evolutionary process. Unless the teacher is prepared to accept the challenge to make education vibrant and relevant, maybe he or she deserves to become extinct.

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CHAPTER 10

MANAGEMENT ISSUES & INNOVATION

SUPPORT OR RESTRICTION OF TC'S: GOVERNMENTAL INTERACTION/SELF-RELIANCE

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Let's start with a simple scenario. Let's imagine that, eight days ago, there was another catastrophic earthquake and fire here in san Francisco. Let's imagine that blocks of the city are rubble and ruins, that a state of emergency has been declared and that health authorities have identified a serious outbreak of typhoid fever; they fear an epidemic. Alarmed and confused citizens, struggling to cope with everything else, naturally want to know how they can protect themselves and their families from disease.

Soon there are official announcements on TV, on radio and in the newspapers. Posters and fliers are circulated throughout the stricken city. They say:

Citizens: Your government is concerned about the medical emergency. Here are your instructions: 1) If you feel ill, make an appointment with your private family physician. Be sure to take your medical insurance ID and forms with you. 2) If you do not have health insurance or other means of paying for health care, stay home. We hope you will not become ill. If you do, do not call your government. 3) Contribute generously to the private hospital or other health facility of your choice. Your government is doing all it can to avoid competing with private health care providers. This announcement will not be repeated.

End of scenario. It's all imaginary. Nothing like that would ever happen in a real public health emergency. Unless, of course, we talk about the plague caused by drug abuse, a public health crisis by any definition. In that case, the fantasy I have just described begins to sound unpleasantly real.

The crisis I mean is not localized in one city; it has reached into them all -- and beyond them. We don't have to imagine the costs -- in human life, in property destruction, in other economic losses. And the critical need for skilled treatment is equally real. We are dealing in every way with a pandemic condition. But when we come to the issue of federal government support for drug abuse treatment, the prevailing policy is clear: Don't get sick. If you do, don't call your government.

In recent years, federal assistance to our service programs have been decimated four times over. We have lost 42% in real dollars during this period, but there is only limited public perception of that devastating damage. At the same time, Mrs. Nancy Reagan has become increasingly identified in the public mind with the fight against drug abuse, particularly on behalf of the young. She is a frequent visitor to programs and is warmly received by them. Earlier this year, she convened an international gathering of first ladies from around the world to express their concern about drug abuse; during their visit to the United States, they were guests of a privately supported treatment program in Atlanta, Georgia.

Mrs. Reagan has also been cordially received and honored by major TCA programs, including those supported by public funds, chiefly state funds. But her strong emphasis on the primary role of "the family" in deterring drug abuse and her strong encouragement of volunteer effort reveal distinct opinions about publicly supported human services programs in contrast to private ones.

The crippling of needed treatment programs has gone on. And Mrs. Reagan's responses to direct questions about the obvious inconsistencies have not always been forthright. This past spring, for example, ABC TV's Joan Lunden asked," Some people in the drug abuse field, while they are very quick to praise you and what you have done to keep the subject of drug abuse in front of the public, are critical of the Reagan administration's cut in federal spending on drug abuse programs. What do you say to them?" Mrs. Reagan's reply was, "Oh, I think their confusion lies in the change to block grants. They gave the money to the states rather than administering it from Washington. They didn't cut back; they gave it to the states. So, now it's up to the states," she added.

In fact, as I've made clear, federal funds have been drastically cut back, in accordance with an administration domestic policy that has been consistently hostile to human service programs at every level. Furthermore, states which have tried to offset these and other losses have been targeted for renewed attack. As the White House Communications Director, Patrick Buchanan, asserted late this spring, the administration's tax reform program was intended, in part, to discourage states from a "neo-socialist approach to government."

All this is part of current history. And as we recall it this morning, I'm sure there are colleagues of his who are thinking, "Well, what's new? What one politician gives you, another can take away. We teach our clients self-help and independence. We have to run our programs that way or we become funding junkies."

That is a serious concern and it has to be addressed as we face the main issues this morning: Hos is state-of-the art drug abuse treatment going to be provided to the millions of Americans who need it and how will it be paid for? With public funds? With private money? With help from both these sources? No other single issue is more critical to our field because none of our skill, none of our experience, none of our carefully developed ability to save lives can be brought to bear unless there are realistic answers to urgent questions about support of treatment.

Of course, there was a time, within easy memory of many of us here, when there wasn't any funding issue. My home agency, and many others exploring the new field of drug abuse treatment, had as little money as experience. We managed, most of us, on small contributions, on the help of volunteers, on donations of secondhand clothing and furniture, on the good will of a few sympathetic people who would offer a roof and a room for nothing. Self-reliance was not a subject for discussion, it was the only way to survive and serve.

In the same way, we relied on ourselves in developing our programs. Medical professionals were skeptical. Mental health professionals were skeptical. Much of the public was either doubtful or hostile to us. But we persisted, and over a generation, we have firmly established a new human services profession, productive and growing. It is now ready, at the time when it is most needed, to care for great numbers of men and women.

We cannot meet that obligation, however, if we are obstructed, hobbled and undermined by official policies based on the idea that private enterprise can be substituted entirely for the kind of public services we provide and that voluntary effort, family concern, "tough love" and other formulations are not only essential for prevention and education, but also enough to assure treatment.

Can the United States do all that needs to be done, socially and economically, medically and psychologically, to treat substance abuse by leaving the whole responsibility to the resourcefulness of privately supported providers?

That is the question. And the answer is, "No."

Is there some reason why expert treatment for drug abusers who cannot afford private-pay or insured health care should be regarded as markedly different from other forms of public health care? That is another major question. And the answer, again, is "No."

Are any of us really free of government regulation now? Do we operate, in any state, without appropriate oversight as responsible community health care providers? No, we don't. On the contrary, we are, most of us, used to meeting official standards and we are often on good professional and personal terms with the people in government who establish and enforce them.

Let me elaborate on some of these questions and answers. The scope of the problem, first of all, is impossible to ignore. There is no accurate estimate of the number of seriously afflicted drug abusers in this country, but no region of the economy is drug-free. In preparing these remarks, I leafed casually through New York daily newspapers for a week, looking for stories about drug abuse and abusers. They came from the fields of professional sports (baseball and basketball), from the film industry, from secondary education, from law enforcement, from corrections and from the judiciary. Yes, many of these abusers can afford private treatment services. Yes, many of them could qualify for treatment through employee assistance programs. But there are multitudes of Americans, including middle class individuals, who will either have treatment that is largely supported by public funds or will not have treatment at all.

That is true of health care generally today. It is, as I've indicated, equally true of substance abuse care. The community-based program, over decades of development, has proved itself an economical, effective alternative to the utterly worthless "detox and discharge" approach which once constituted the federal government's treatment program.

And the same originality and ingenuity that has been characteristic of therapeutic program development is just as obvious in the variety of approaches we take to assure financial support and stability. Some of us function with no public funding of any kind, some of us work with a combination of public and private support. Some of us function with no public funding of any kind. Some of us work with a combination of public and private support. Some of us depend almost entirely on government contract support. Some of us operate successful businesses which can serve several positive purposes: meeting community needs for goods and services, giving clients valuable voc/ed experience and also the sense of achievement that is critical to successful therapy. Some of us -- my program is one -- face a relentless, heavy demand for human services from a huge volume of prospective clients in localities where there is always a surplus of unskilled and semi-skilled labor. For us, successful treatment demands not only recovery from drug abuse, but also that we supply top quality education and job skills. That can't be a part-time job, and private funding isn't enough to support it. So my program, and others like it, have special obligations when it comes to involving clients in fund-raising. Early this year, for example, we started planning for our annual raffle. Raffling is popular in

New York; there are some programs that raise most of their income from it, and Samaritan's young people do well at making money and making new friends for us.

But, as we've done in the past, we set a $100,000 cap on the raffle. We think that's realistic. Samaritan needs community support, but our clients need to become more self-supporting. That, I think, is the fundamental obligation we all have. All of us must meet our responsibilities to people in treatment. Those who can do this successfully and independently, with the help of their clients, deserve attention and respect. So do those who must rely on public funds to turn former drug abusers into useful private citizens. In fact, I would argue that the public's stake in this process is so clear and urgent that government should assume a reasonable share of the support of every accredited drug abuse treatment program now functioning -- exactly as it does in assisting a wide range of health, education and social programs.

Am I actually going to use the word "entitlement" in this connection? Yes, I am. There is no other rational answer to the obvious needs for service.

Now, let's look a little more closely at the "overregulation" issue. At my agency, one of the principal assignments of the Vice President for Administration is to maintain full compliance with local, county and state health care standards. We not only manage to do this, we thrive.

The reason is that we are continuously enlarging and extending health services. For instance, we decided early that our residential facilities should qualify as diagnostic and treatment centers under the New York State health law. This responsibility was not forced on us; we looked for it because we were determined to improve our program. I am sure that sense of professional commitment is shared by everyone here and that many of you have taken the same approach.

Moreover, as we have, you have made associations with elected and appointed officials. "Government" is not some grim and threatening abstraction; rather, it is embodied in often conscientious and helpful public servants who share your sense of obligation to help when there is no other source of help, who are determined that contracted services will be first-quality services.

In other words, "regulation" does not inevitably mean "overregulation" any more than receiving public support means an end to private initiative and innovation.

Against this larger background which I have sketched, I do not see that there should be either controversy or contention over program support, nor attempts to set up standards of acceptability, nor claims of superiority for one approach over another.

As professionals, we all welcome the opportunity to innovate, to develop, to reach new people in need. We can share our research, exchange our experience, extend the boundaries of our whole field. We can respect each other. I believe we do.

GOVERNMENTAL SUPPORT: A SWEDISH PERSPECTIVE

Lars Bremberg, M.A., L.L.M.

Vallmotorp, Daytop Sweden
Katrineholm, Sweden

Sweden is a welfare state, and this predetermines the rules for our TCs. The aim of the Welfare State is to guarantee citizens a high, secure and equal standard of living. To obtain this a strong sector for government and local government activities is needed. It requires a well developed bureaucracy to organize and control the system, and various fields in society will be run as state monopolies. In Sweden, the medical and social welfare sections constitute such monopolies. As a consequence, the treatment of alcoholics and drug addicts is considered a task for central or local government and private operators are allowed only if they follow the rules.

When a new need occurs, like alcoholism 70 years ago or drug addiction in the 60s, the government often uses state subsidizing to stimulate the creation of facilities, although this is mainly directed to local government agencies. As the production and sale of alcohol is a state monopoly, it has long been considered a moral obligation for the government to cover most of the costs incurred in the treatment of alcoholics. However, there is at present a tendency to depart from this costly tradition. The running of day centers for children, home services for the elderly and the rehabilitation of drug addicts have lately been such fields in focus. The economic support is usually withdrawn when the expected results are obtained. The Vallmotorp foundation received state subsidies at its start in 1973, but the subsidy value has gradually diminished with the impact of inflation and it will disappear completely by the end of this year; a fact that we are considering bringing to the notice of the courts.

It is not, however, the support that has been responsible for restrictions which TCs, such as Vallmotorp and Daytop Sweden, run by private, non-profit tax-exempt organizations, have been made to suffer, but rather the control that a number of central and local government agencies are exerting mainly in respect of localities, fire protection, plumbing, and so on. Nonetheless, we have always been one step ahead of the government as far as the treatment program is concerned, and so far fortunately, there has been a general acceptance that organizations like ours -- free from bureaucratic restrictions when running a treatment program -- are more successful and lead the way in the development of methods. They are, on the whole, more effective at a lower price.

In the end, of course, it is the taxpayer who has to provide the money, as clients themselves, or their families, can seldom do more than contribute a small portion of the treatment costs.

Thus, our income is made up of about 90% fees paid by local government welfare agencies. This means that we operate on a market where we have to present a good product at an attractive price, otherwise we will, pretty soon, be out of business.

This is the extent of the acceptance of private rehabilitation programs in the welfare state.

DELANCEY STREET FOUNDATION: AN EXAMPLE OF SELF-RELIANCE

Mimi H. Silbert, Ph.D.

Delancey Street Foundation, Inc.
San Francisco, California

Delancey Street is considered one of the most unique and successful programs in the country. We currently have over 600 residents located in four facilities throughout the country: San Francisco, where we've been for the past 15 years; on a 17-acre ranch in rural New Mexico, where we incorporate a juvenile program with one designed for adults, in operation for seven years; a large castle and several surrounding buildings on 90 acres in Brewster, New York, about 45 minutes outside of Manhattan, where we've been in operation for four years; and our newest Delancey Street in Los Angeles.

Our population ranges from ages 12 to 68; approximately 1/4 women; 1/3 Black, 1/3 Hispanic, and 1/3 Anglo. Despite the violence in the backgrounds of our residents, there has never been one incident of physical violence in Delancey Street, nor has there ever been one arrest.

We have graduated thousands of men and women into society as tax-paying citizens leading successful lives, including lawyers, realtors, sales people, the various medical professions, truck drivers, mechanics and garage owners, general plumbing and electrical contractors as well as many in the trade unions, printers and business managers, prior president of the school board, member of the San Francisco Board of Supervisors, and even a deputy sheriff.

Our successes have been touted by such notaries in the field as Karl Menninger, along with many of the media, including a 60 Minutes segment, a segment on CBS Morning News, The Today Show, a number of nationally circulated periodicals, many commendations from state legislatures, professional organizations, local majors and boards of supervisors in areas in which Delancey Street resides, along with commendations from professionals ranging from law enforcement through community agencies.

One of the most unique features of Delancey Street is that we have never accepted any government funds in the 15 years of our existence, nor do we have any staff. Aside from its president, everyone else in Delancey Street is also a resident in the process of changing their lives. No salaries are paid, not even to the president of the Foundation. Instead, everyone works. Everyone is both a giver and a receiver in Delancey Street. The Foundation supports itself primarily through a number of training schools which provide vocational skills to all the residents, and also, through pooling the monies earned, generate the Foundation's income.

Although we recently closed our restaurant in San Francisco, we still maintain ten other training schools, including: catering, an automotive training school (and antique car restoration); Christmas tree lots; a construction school; a moving school; a national trucking operation; printing and buttons production and sales; furniture, small wood products, bark planters and terrarium production and sales; a national advertising specialty sales department; and a paratransit service for seniors and other mobility impaired clients. Because the residents perform all the functions of Delancey Street themselves, there are numerous other departments which function as vocational training for residents but which do not provide any income because they serve simply in-house functions. These include bookkeeping and accounting departments, legal affairs, education, food service, secretarial skills, and computer skills, among others.

Catering Company

Our catering company provides full catering services both through the use of our own facilities and transported to other facilities. Catering offers a wide range of products, from hors d'oeuvres to full ten-course sit-down dinners provided for as many as 500 guests. Along with the production and service of food, catering includes the decorations and entertainment entailed in planning the events we service, including weddings, proms, business seminars, and specialty dinners.

The catering department trains approximately 30 people per year in menu developing and planning, food purchasing and preparation and serving, facility decorating, rental and estimating, and other skills.

Automotive Department

Our automotive department provides complete instruction in basic auto mechanics, oil changes, tire changes, tune-ups, routine general maintenance and complete engine repairs for over 30 residents yearly. Students work on a wide range of vehicles from passenger cars to diesel rigs, tractors and heavy duty equipment. Automotive services over 100 vehicles at any given time. In addition to mechanics and body work, it offers practical experience in antique car restoration. To date the Foundation has refurbished eight antique cars, learning engine and chassis rebuilding, electric wiring, body work, painting and upholstering. Numerous of our antique cars have won prizes in various Concours d'Elegance competitions.

Christmas Tree Lots

Delancey Street maintains six Christmas tree lots throughout the Bay Area. conducted each year only between Thanksgiving and Christmas, this brief holiday promotion is, nevertheless, the source of a significant share of our total earned income. Also significant are the diversity and complexity of merchandising skills it calls into play, among them on-site selection of prime stock from Pacific Northwest tree farms, construction of tree stands,and providing sufficient personnel, supplies, and equipment to ensure maximum operating effectiveness, timely delivery to each lot site of trees chosen for suitability of size, type, and price, accountability for cash receipts, security and ongoing maintenance of leased properties. The operation of the lots themselves and sales of Christmas-related products to banks and businesses involve the training of about 75 residents each year.

Construction School

All Delancey Street residents and business enterprises are housed in structures brought up to acceptable occupancy standards and building code specifications solely through the efforts of our construction school workmen and women under the direction of residents holding contractors' licenses. Each of the Foundation's four sites reflects architectural disciplines unique to its cultural and geographic influences; each has been enhanced through the introduction of improvements (restoration, remodeling, rehabilitation, new construction) conceived and carried out by resident craftsmen. Significant among ambitious projects adding immeasurably to each property's esthetic and monetary value are:

1) The restoration of a Tudor-inspired stone castle, two pre- Revolutionary War dwellings and an abandoned carriage house, all evocative of upper New York state at the turn of the century;

2) Complete restoration of four buildings in San Francisco, including a stately Edwardian mansion for which a self-taught Foundation artisan created, assembled, and installed a series of stained glass windows;

3) The complete renovation, including new floors, ceilings, walls. all new bathrooms and kitchens, of a former hotel and restaurant currently housing over 200 residents;

4) The remodeling, inside and out, of an uninhabitable apartment building in Los Angeles;

5) Construction by the Foundation's New Mexico work force of a 40,000 square foot business complex which accommodates a laundry, an automotive service center, a print shop, a sewing shop, officer and conference rooms; and a complete catering kitchen, built entirely in the authentic Southwest style. In fact, this building is the largest new edifice built in this style in the history of New Mexico;

6) Construction and installation on DSF/NM grounds of a completely self-sufficient sewer system and water treatment plant capable of serving a town of 5,000 people;

7) Construction of two large dormitories around a central courtyard, complementing the Southwestern flavor of existing buildings;

8) Additional new construction in New Mexico to provide six apartment units and an industrial facility incorporating a garage, several offices, and a large workshop.

Moving School

The Delancey Street moving school has been in operation as a fully licensed and insured mover with the statewide authority in California for 13 years. It consists of 40 fulltime experienced movers, with a labor pool of another 50 people. Our fleet consists of 112 bobtail moving trucks 24 feet long, 3 big rigs with 45-foot electronic vans, and 1 28-foot electronic van. The school designs and constructs all of its own dollies and other rolling stock. The Delancey Movers provide full service moves which include packing and crating safes and pianos.

Current contracts held include the G.S.A. term contract for the entire Bay Area, the term contract with the City and County of San Francisco, the term contract with Caltrans District IV, along with numerous other individual contracts, and, of course, the movement of household goods throughout the state. The largest single job completed by the school was for the U.S. Geological Survey, which consisted of 2.5 million pounds of geological samples and related equipment. The move took 82 working hours and was accomplished without a single instance of damage.

National Diesel Trucking

The national diesel trucking operation consists of classes for students conducted on a year-round basis and includes knowledge of and practice in the operation of diesel tractors. Delancey Street's diesel rigs runs regular circuit from San Francisco to Los Angeles to New Mexico to New York and return on a continual basis, requiring not only truck driving skills but knowledge of Interstate Commerce Commission rules as well as those enforced by state and local regulatory agencies.

About 50 men and women are trained and licensed in trucking skills each year.

Print Shop

Delancey Street's print shop not only generates income by making its services available to local merchants, it draws from the same resources to meet recurring Foundation requirements for stationery, printed forms, invitations and advertisements. On-the-job training entails every aspect of printing technology from image preparation to product finishing.

Most recent of our income ventures is based on the design, manufacture and sale of imprinted buttons. Personnel are taught such procedures as inventory control, order processing, assembly, and shipping. They work closely with the print shop and art department technicians.

Buttons are sold both as advertising specialty items and wholesaled to stores (for example, in the tourist areas of cities as well as hospital gift shops, college book stores, etc.).

Craft Products

Delancey Street is gaining a reputation for its finely worked craft products. For 13 years Delancey Street has developed its own bark planter products, which it has wholesaled to various nurseries along with terrariums. Delancey Street designs and hand crafts sand paintings, stained glass windows, furniture made in the Taos style, and numerous other hardwood items. These are produced completely by Delancey Street residents and are sold by residents to both wholesale and retail markets throughout the country. Over 50 people are trained in this department yearly.

Marketing Department

Delancey Street maintains a large marketing department which has a number of components. Residents are trained to sell to businesses corporate recognition gifts, service and safety awards, and sales incentives. These products are used by many companies as a means of keeping their names constantly in front of their customers. Because we are members of the Advertising Specialty Association International, we have access to the product lines of over 2,000 suppliers. Salespersons travel to businesses throughout the country. In addition to the sales of the products, we maintain our own record keeping and order processing departments, as well as an art department capable of creating the special art work needed for many of the products.

We have developed a specialty market in this field with college book stores, maintaining a product line imprinted with school emblems and sorority and fraternity insignia for resale in school book stores. This college market services over 1,500 college and university stores. Currently each of our Delancey Street locations services our clientele by regions. The New York sales office services New England and the mid-Atlantic states; New Mexico services Texas, the Midwest, and the South; our Los Angeles office services Southern California and the Southwest; our San Francisco office services Northern california and the Northwest.

We also have established accounts in the retail market from all four locations. These products include the Lou Broc line of sports miniatures and numerous impulse items such as Trivia games, particularly for discount drug stores, airport gift shops, and military exchanges in an ever-expanding market. The National Advertising Specialty Department is our most sophisticated training concept. We are able to train about 60 personnel, traveling locally and throughout the country, annually.

Paratransit

Paratransit training is an exciting project for Delancey Street because through it we were able to turn a volunteer service into an actual skills training and income generating situation. For the past ten years, Delancey Street has escorted senior citizens and provided entertainment and activities, including a weekly dinner at one of our facilities for numerous seniors in the community. For the past two years, Delancey Street, under contract to the Public Utilities Commission and the City and County of San Francisco, has been providing unlimited group van service for handicapped, elderly and disabled residents who are unable to use public transportation by themselves and who are thus certified by the city to use paratransit services.

Delancey Street's service is unique in that we provide trained escorts in addition to trained drivers on each van, and we have already received several mayoral and agency certificates and proclamations because we were able to save lives through quick action and CPR training while accompanying seniors on the vans.

About 25 residents are trained in this fulfilling marketable skill throughout the year. Upon graduation they are able to provide transportation service not only for seniors and mobility impaired clients, but for general transport companies as well.

There are many reasons why Delancey Street is able to be so successful in a field otherwise fraught with failure. For one, we understand that change is not an easy or a short-term process. To change not only the self-destructive behavior of substance abusers and criminals, but to change their antisocial attitudes and self-denigrating feelings as well, requires a long time, a very hard lines, and a complete re-education.

All our residents receive a high school equivalency, despite the fact that the average resident is functionally illiterate upon entering Delancey Street. They must receive vocational training in at least three marketable skills, are taught to interact successfully with others, and learn a great deal about themselves. We are unique because we are willing to stress the old-fashioned values of decency and dignity, of achieving a sense of self respect through working hard and earning it, of reaching out and helping others as a way to feel good about oneself. We teach self reliance by taking the large risk of not having anyone fund us, but of earning our money based on the strengths of our residents at the same time as we teach them to turn around their weaknesses.

I am really proud of what we have accomplished and would welcome the opportunity to show you our organization firsthand. The humor and energy and sense of hope which permeate our work are simply not able to be captured on paper.

THREAT TO NATIONAL SECURITY: DRUGS IN THE WORKPLACE

Lois Morris, M.A., C.A.C.
Anthony E. Miles

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The central concept of this paper--the idea that occupational drug abuse seriously threatens the stability and integrity of the United States--developed from my visits to companies and unions to describe Brightside Lodge. Brightside Lodge is the name of the new program Daytop Village has developed to help employers and employees deal with the crisis of drug abuse in the workplace. When I began visiting companies and unions to describe Brightside, I felt that my job was to highlight the unique and best features of Brightside's treatment and training and consulting services.

I have come to realize, however, that we who work in the occupational drug abuse field have a job that is more vital than simply describing our product. Anyone who is working in the occupational drug abuse field, up to capacity and in good faith, is helping to fight a problem that, if unchecked, will in no uncertain terms undermine the stability and the national security of the United States.

The Relationship between Productivity and Peace

The resources of the world--land, food, clothing, and shelter--are limited. Citizens within any country must strive to receive their full rights as citizens and an equitable share of national resources. Even at peace time nations must compete in world economic markets for their individual share of the world's limited resources.

Prosperity and peace are thus not unrelated. To promote one usually promotes the other. The economic well-being of its people is often a nation's greatest single protection against civil strife and war. Economic isolation and military force go hand in hand. When nations cannot get what they need through the normal processes of trade, they will resort to force. a people driven to desperation by want and misery is at all times a threat to peace. By contrast, a people employed and in a state of reasonable comfort is not one among whom class struggle, militias, and war can thrive (1). this correlation between peace and the economic well-being of nations was seen and analyzed by then U.S. Secretary of State Hull shortly before the United States entered World War II.

The paper which follows develops Secretary Hull's theme of the interconnection between a nation's economic security and peace by addressing the current threat to the U.S. economy and national security posed by drug abuse among american workers. The paper also delineates productivity-oriented tools to deal with occupational drug abuse.

The analysis presented in the paper addresses specific conditions of drug use among workers in the United States in the 1980's. I believe, however, that it also applies generally to other developed and developing nations which are also experiencing the problem of drug abuse in the workplace.

Work and the American Economy: The 1980's

The United States in 1985 is militarily at peace. Yet it is engaged, like all other industrialized nations, in a fierce struggle to maintain internal economic stability and its position in world economic markets. If the United States lost that struggle, the high standard of living contemporary Americans have come to expect could no longer be guaranteed. Already many younger Americans accept the fact that fewer will be able to replicate their parents' high standard of living. Fewer young Americans now own, or can expect to own their own home. It is becoming increasingly more expensive to support and educate children. Having children is thus often postponed or decided against. The nation's families are consequently becoming smaller. At the same time, increasing numbers of Americans are becoming unemployed. Laid-off workers who do become re-employed often find themselves in new jobs that are less skilled and that pay less.

Counseling unemployed American workers in the 1980's still means providing them with support during a distressing transition period, honing their employability, and practically assisting them to find jobs. In some other Western industrial nations, however, counseling the unemployed means teaching people to adapt to long-term or permanent unemployment. The United States itself is hardly untouched by the economic distress many industrialized nations are experiencing. The U.S. balance of world trade--its export to import ratio--has become highly unfavorable. Detroit, America's industrial capital, has been severely shaken by massive layoffs of steel and car factory workers. Many o these workers have been forced to trade in the high wages of a skilled, unionized workforce for unemployment payments or for the lower wages of unskilled labor.

U.S. Drug Abuse in the 1980's

The United States in 1985 faces many peacetime threats to its integrity as a nation. One of the most serious is growing drug abuse among middle-class Americans, including many permanent workers and professionals formerly removed from the hurricane eye of the United States' drug abuse problem.

Something new is happening in America, divergent from its recent past. There was limited national concern in America during the 1050's and 1960's when 61% of the youth of Harlem were using drugs. Only later did important people, respected members of their communities and professionals, begin to feel the impact of a son or daughter arrested for drugs--or themselves face arrest for possession, use, or sale of illegal drugs (2). Housewives and working women began to discover that they too could become addicted to legal drugs--or illegal ones. Growing numbers of blue collar workers, like white collar workers and professionals, have also become chemically dependent. Because America's drug abuse problem in the 80's has heavily infiltrated al segments of the U.S. population, all classes, and all ages, our country now faces the most serious drug problem in its history.

The fact that drug abuse has spread to and deeply penetrated all segments of the American population, including the most stable and productive elements, is cause for the greatest concern for the welfare of the nation. For a nation whose workforce and professions contain large numbers of alcoholics and addicts will not be productive or successful in the international business arena. Continuation of current drug abuse trends can even interfere with adequate national defense.

Any country can be thoroughly defeated internally when citizens' business initiative is based on the inconsistent and failing inspiration and stamina supplied by stimulant drugs such as cocaine and amphetamines. A nation of workers, business leaders, military personnel, and professionals made passive by drugs such as marijuana, heroin, and alcohol, cannot marshal needed creative aggressiveness and initiative for its work and cannot competently defend itself. Such a nation cannot succeed in appropriating for itself a satisfactory quality of personal, family and community life--or a high economic standard of living.

A nation whose school children in some cases begin, by the age of nine years of age, to buy illegal drugs in school buildings and grounds, a nation whose school children can buy drugs from classmates and sometimes even from teachers and counselor, is a country defeated if it does not change. This is the status of American schools in 1985--especially, but not only, in large urban centers. Substance abuse among preadolescent and adolescent children, like addiction among U.S. workers, is, without reservation, alarming.

The problem of occupational drug abuse which threatens U.S. national security is not, however, without solutions. A serious, well-funded national prevention and rehabilitation effort can be mounted to end this severe threat to America's integrity and strength. The successful technologies and strategies which the United States is now developing to fight occupational drug abuse, can and will be shared with other nations faced with a similar problem.

Brightside: Daytop's Occupational Drug Abuse Programs

My agency, Daytop Village, is a major East Coast drug treatment program which has successfully fought drug abuse for 22 years, treating over 40,000 youthful and adult substance abusers. Daytop is now turning its attention and harnessing its full organization resources to provide effective, low-cost treatment for employed persons who abuse or are addicted to drugs.

The primary tool that Daytop has developed to fight drug abuse among the nation's professionals and working people is Brightside Lodge. Brightside Lodge is the name for 3 principle occupational services that Daytop has developed. The 3 services are: 1) Brightside Lodge, a 30-day residential program for professionals and working people; 2) the Brightside Outpatient Program; and 3) Brightside Productivity, Training & Consulting Services.

Brightside Lodge: Short-Term Residential Treatment

1) Brightside Lodge. Brightside Lodge is an intensive 30-day rehabilitation program that forms the nucleus of Daytop's occupational treatment services. Brightside Lodge represents Daytop's first step in meeting the $16 billion problem of drug abuse in the American workplace. It is, however, just the start of Daytop's response to the problem of industrial drug abuse. Brightside Lodge will eventually fit into a larger complex of occupational services that will be named the Thomas M. Macioce Center for Personal Renewal.

Brightside, while treating all forms of occupational drug abuse, including dual addiction to alcohol and drugs, will focus specifically on the widespread problem of cocaine abuse in white collar and blue collar industries. Brightside staff have extensive experience in treating cocaine abuse. This expertise is available to assist the cocaine abuser to recover and to help family members and significant others support the cocaine abuser's recovery while they get the understanding and help they also require.

Brightside will provide specialized treatment for cocaine abuse on both an outpatient and inpatient basis. It will also treat individuals addicted to other drugs. Typically, a chemically dependent employee will participate in the following three-phase Brightside Lodge program:

Phase I: 30 days of intensive treatment

Phase II: 11 months of outpatient treatment

Phase III: 1 year of voluntary aftercare

Occupationally impaired individuals who do not require intensive residential treatment will instead begin treatment in Brightside's Outpatient Unit.

2) Brightside Outpatient Unit. Most substance abusing employees entering the Brightside program will begin treatment in the 30-day Brightside lodge rehabilitation program. After 30 days of residential treatment, the individual will enter outpatient care for 11 months.

Brightside is also able to draw upon the resources of Daytop Village to treat severely chemically dependent employees who need more intensive care than Brightside's typical 30-day residential treatment followed by 11 months of outpatient treatment care. Clients needing more intensive treatment can be referred to Daytop for long-term residential care or to one of Daytop's ambulatory care programs.

3) Brightside Training and Consulting Services. In addition to providing direct treatment, Brightside offers training and consulting services in four principle areas:

Drug Abuse Risk Prevention Consultations
Supervisory Training
Productivity and Quality of Work Life Consulting Services
Substance Abuse Seminars

Drug Abuse Risk Prevention Services. Brightside will send a prevention team into the workplace to assess organizational structures, work roles and environmental factors that predispose work sties to high rates of employee substance abuse. The team will recommend adjustments in work structures that are needed to reduce the risk of drug abuse. The team will also help the employer or union start a drug prevention program.

Supervisory Training. Brightside provides training to supervisors and union personnel in intervention strategies to maximize occupationally impaired employees' recovery potential. The training is also designed to minimize productivity losses to the company.

Productivity and Quality of Work Life Consulting Services. A Brightside consulting team will help companies and unions cut the productivity losses they face from employee substance abuse by 1) redesigning organizational structures and roles to enhance organizational productivity and the quality of work life within the organization; 2) designing and implementing heavily productivity-oriented drug abuse prevention programs in the workplace; and 3) providing employee assistance program (EAP) referral and treatment services.

Substance Abuse Seminars. Brightside's multidisciplinary consulting team will visit companies, unions, work sites, and agencies to present seminars on drug abuse and related issues.

The Rationale for Short-Term Residential Treatment

Recovery rates of alcoholics treated in occupational rehabilitation programs are often as high as 70-80%. These recovery rates are considerably higher than those for unemployed or marginally employed alcoholics. The greater family and social support that employed substance abusers more often enjoy, and the employee's need for a steady job, are pivotal factors supporting the chemically dependent employee's recovery.

Unlike alcoholics who have their own short-term rehabilitations, however, before Brightside drug dependent workers found it difficult to find low cost, short-term and drug-specific residential treatment. Drug abusing workers usually had to enter alcohol rehabs to find the short-term residential treatment they needed. These alcohol rehabs have proven to be tremendously successful at rehabilitating alcoholics, but not at rehabilitating drug abusers or ly dependent employee's recovery.

Unlike alcoholics who have their own short-term rehabilitations, however, before Brightside drug dependent workers found it difficult to find low cost, short-term and drug-specific residential treatment. Drug abusing workers usually had to enter alcohol rehabs to find the short-term residential treatment they needed. These alcohol rehabs have proven to be tremendously successful at rehabilitating alcoholics, but not at rehabilitating drug abusers or dually addicted persons.

A long-term drug treatment program was the unsatisfactory alternative left to the drug dependent employee who did not want to enter an alcohol rehabilitation unit. The price for utilizing this alternative was often termination of the employee because of his or her extended absence from work.

Brightside Lodge was instituted to help solve this problem. Brightside's 30-day rehabilitation program is designed specifically to help employees protect their jobs while they seek treatment for substance abuse. The cost of ending addiction, as Brightside sees it, should never be termination from one's job.

Brightside's Strong Therapeutic Community Roots

Brightside Lodge is one of the first drug treatment therapeutic communities being developed in america to provide short-term drug-specific residential treatment for employees who are drug dependent. Brightside's program, while based on the TC model, also utilizes effective new treatment modalities from a wide variety of health care disciplines. Brightside has additionally developed its own innovative treatment methodologies, such as Work Motivation and Attitude groups, to maximize clients' recovery potential.

Brightside has retained all critical core characteristics of the TC, including a strong emphasis on family and work and accountability to peers. It has, however, enriched core TC components such as Daytop's traditional TC family milieu therapy and encounter groups to provide the most effective possible treatment for a new treatment population--chemically dependent employees.

Brightside Treatment Components

The Brightside treatment team will be comprised of an experienced professional and treatment program graduate staff working side by side as equal partners. This model has proven to be far more effective than any other treatment modality developed to assist drug abusers. Brightside treatment components will include:

One to One Counseling
Stress Management
Encounter Groups
Pastoral Counseling
Psychological Counseling
Sexual Counseling
Work Motivation and Attitude Groups
Group Therapy
Drug Abuse and Alcohol Education
Family Counseling
AA and NA Groups
Aerobics and Team Sports, Swimming and Hiking
Networking Groups
Single Life Styles Groups

Brightside Women's Lodge: an innovative treatment program to deal with the special needs of female employees.

The TC as a Resource for Increased Productivity

The therapeutic community's usefulness to industry extends beyond the treatment it can provide for workers addicted to drugs. The TC can also serve as a catalyst promoting industry's adoption of more efficient work structures. Brightside Lodge, like other therapeutic communities, can assist national productivity in all of the following ways.

Brightside Prevention, Productivity, and Training and consulting Services will assist employers and unions in setting up formal drug abuse prevention programs for employees that include analysis of risk factors for substance abuse within the work environment. Brightside can help the company and union resolve problems in how employees fit into company organizational structures since unresolved problems in these areas can mean both low productivity and high employee turnover. The dominant supervisory style of the company is also carefully analyzed for its impact of productivity levels and quality of life in the work environment.

How time is structured in the workplace must also be carefully considered since it can become either a severe substance abuse risk factor or a cornerstone of high productivity. Businesses that employ workers on late shifts or double shifts or that assign employees extended work shifts split by layover time in distant cities are generally at higher risk for substance abuse. Unusual work schedules make it more difficult for employees to constructively structure family life and leisure time and thus place them at higher risk for substance abuse.

Work environments are also at high risk for employee substance abuse when people work under demanding work conditions: under extreme stress, in occupations where there is a strong drug-use image; in jobs that are monotonous and repetitious; in jobs where there is a high level of antagonistic interaction with the public or co-workers. Employers interested in the maintenance of a productive work environment and in low turnover of employees cannot afford to ignore these risks. For once abstract risk becomes actual employee drug use, it is unlikely that the employee will remain productive at work or in any other aspect of life.

TCs and the Business Community: A Working Partnership

The role therapeutic communities can play in assisting their host nations to maintain high levels of productivity through the TCs productivity-related Prevention, Training, and Consulting Services represents a new direction for the therapeutic community. Yet it is a direction that may become the TC's most important work. This is so because genuine productivity means much more than a game of employers trying to get more out of workers' hides while workers resist.

National productivity is a critical variable closely associated with a citizen's standard of living and quality of life. It is a variable that is also often co-related with a country's willingness to seek peace with its neighbors or readiness to be pushed to war because of economic distress.

National productivity, if properly apprehended and appropriately pursued, can mean a good life for all citizens in the nation and peace with neighboring countries. If misconstrued and mismanaged, this critical fact of national life can alternatively mean grievous suffering to employees displaced by greed-centered business or through the shortsightedness of humane employers unable to adapt their work operation to technological advances.

An expressed concern for productivity can be a disguise for exploitation of human resources. Misapplied productivity approaches can lead to open war on workers and open warfare between unions and business. Yet a company of nation's drive for higher productivity, creatively managed, can mean strong business and strong unions cooperating to invent productivity initiatives that are not short-sighted and ultimately wasteful of human, social, and financial reserves. A proper balance of self-interest and cooperation is required of company and union. Employed people possess enormous knowledge of work and enormous potential creativity and initiative. Properly tapped by industry, these resources will make the employed successful and lead to higher levels of national productivity, a stronger nation, and a satisfied work force.

Symptoms of national decay, including high unemployment rates and large numbers of professional and permanent workers becoming addicted to drugs, must be reduced if national productivity is to rise and the nation's citizens are to continue to enjoy a comfortable standard of living. At the very least, the employer can look forward to reduced drug abuse at work sties where the therapeutic community intervenes with prevention programs and direct treatment of chemically dependent employees.

The TC cannot solve all national productivity problems; it can assist in resolving some. The TC can provide direct assistance in one important productivity area--work impairment due to drug abuse. The TC is now doing this by designing innovative programs to effectively rehabilitate drug abusing workers.

The therapeutic community can also significantly assist national productivity by analyzing risk factors in job design, hierarchy of work roles and organizational structure which contribute to employee substance abuse. By creatively pursuing the narrow goal of reducing employee drug abuse, the TC can more broadly assist industry in evolving worker-humane, productive, and financially profitable work structures and systems.

The therapeutic community, with its successful history as a community dedicated to achieving both functional and human goals, embodies a model that the workplace can learn from. In the same manner, we, the therapeutic community, have much to learn from the business community which we wish to serve.

COMPUTER TECHNOLOGY & THE TC

David Kerr, M.S.W.

Integrity House,
Newark, New Jersey

This paper contains descriptive information and copies of printouts from a computerized system for managing your TC and related programs. This system was originally created and modified for Integrity Inc., and was installed in 1982. Presently the system is being modified and enhanced to accommodate a more extensive client management system as well as programs utilizing methadone maintenance.

The system appears to be unique particularly in offering financial reports that are segregated by cost centers and particular program locations. In addition, it has a unique management oriented statistical report that automatically prints once a month, as well as a client management and tracking system segregated by counselor caseloads, program locations and cost centers. It is therefore particularly well-suited for multi-modality programs that want to maintain unique financial and client management data by contract or by cost center.

If you are interested in finding out more about this system, call or write to me at 201-623-0600 or call Queue Associates directly at 201-229-1212, and ask for Jim McMillan or Leslie Wilcox.

This system is available for the IBM PC/AT, IBM XT AND IBM System 36. It is designed primarily for users who need the advantages of a diversified accounting system in an integrated package. A set of individual menus allows the user to switch from one system to another easily. This system is designed for clinic sue and is easily understood by all in this environment. Each of the users has successfully installed this system, including parallel processing, within three months of purchase.

This package includes the following files:

Client Master File

This file contains information about each client's status (client number, name, address, etc.) used for generating reports and statements. It also contains demographic and admit/discharge account information for quick review.

Guarantor Master File

This file contains information about each guarantor (guarantor number, name, address, contact name).

Charge Data File

This file contains data on charges entered into the system and used in generating invoices. Each charge entered contains the following information: description of charge, guarantor number, amount of charge, branch/dept/year this cycle.

Dictionary File

This file contains information which defines demographic informtion pertaining to your Client file. Each demographic entry has one "header" record (field number, description, etc.) and one detail record for each field defined.

Invoice Master

This file contains all the necessary information for generating receivables. Each record contains invoice number, guarantor number, client number, date, amount, etc. One record is maintained for each invoice created. In this way, all reports reflect current amount status.

System Control File

This file contains various control information such as the starting invoice number, clinic name and phone numbers, methadone inventory, etc.

Temporary Billing File

This file holds the information required for this cycle and is used only when the billing process is being executed by the clinic.

In addition to standard listings of all files, the following reports are included in the standard package:

Aged Trial Balance

You may choose to have a summary aged trial balance or a detailed trial balance printed. Either report results in a summary account line aged over current, 7, 14, 21 and 28 day periods. This reports prints in customer order and subtotals for each.

Customer Master List

This is a listing of customer information from the customer master file. This listing maybe produced in customer number sequence or in alphabetical order.

Invoice Register

This report is a listing of all invoices on file. The register may be printed in invoice number sequence or customer number sequence.

Payment Auditing

This produces an audit listing of payments and adjustments and can be used to verify bank deposits. It also shows the status of each invoice that was updated during this routine.

Labels

Labels can be printed for the following files: guarantors, clients, urinalysis, and methadone dispensing.

Demographic Analysis Report

This is the report which prints all demographic information by client number. It will subtotal and total by Program codes, defined by the dictionary file.

Dictionary File Master List

This is a listing of all dictionary records currently on file.

Admittance/Discharge Report

This report prints all clients with discharge and admittance information.

Charge Report

This is a listing of all charged loaded in this billing cycle. This can be printed in three ways: by client, by charge and by staff member.

Interim Billing Register

This is a listing of all charges being billed currently. It prints in client/guarantor order and subtotals for each client.

Guarantor Master List

This is a listing of all guarantors on file. This can be printed in two ways: by guarantor number or alphabetically by guarantor name.

Statements

This system will produce statements on pre-printed forms by guarantor.

There are four sub-menus to this package accessible from the system menu which appears as follows:

Client Management / Accounts Receivable
System Menu

[01] Load and Maintenance for Files

[02] Charges and Payments Processing

[03] Billing and Accounts Receivable

[04] Miscellaneous Reports

[05] Change Entity and Backup Procedures

[06] End Processing

Nearly two years ago Integrity, Inc. purchased an IBM System/23 microcomputer. The computer was purchased for the purpose of running all of our financial systems including billing and receivables, accounts payable and general ledger.

Integrity has worked with a programmer to specifically tailor the receivables system to our needs. The following are some of the benefits of the software:

1) It is especially useful for those agencies looking for extensive billing systems to accommodate growing fee for service funding.

2) The system allows individual billing per cent or per contractor, keeping track of receivables on an individual basis or as aggregated by department, facility or contract.

3) This system keeps track of all monies paid in on an individual basis or per contractor or department as well.

4) This system is helpful in justifying third-party payment from insurance companies since it will show actual billings and receipts which tie in to fee schedules.

5) In any billing system there is certain basic information that has to be gathered on each customer or contract. In this system some basic demographic information was gathered for future statistical analysis. This system will print out a statistical analysis for any agency by program or department for any time period designated. Certain valuable information will be provided here including type of referral, race, sex, source of referral, county, drug of abuse, cost of habit, jail time, months spent in program, etc.

6) These statistics can be used for marketing in that they will show the amount that cents or members were spending on their habit per week or day as well as the cost to the taxpayer of the months they spent in jail prior to entering the program. We have found that this information has a tremendous impact on duning sources and trustees.

7) By using certain procedures, individuals "treated" in certain facilities in an agency can be tracked through the "re-entry" phase and into their aftercare phase. Tagging these people initially in the residential TC phase will enable an agency director to see how many of his/her members make it through the program and finally to graduation. This is especially helpful for directors of larger agencies when one facility seems to be showing dramatically better retention through the program than another facility, for example.

8) This software program can also print mailing labels sorted by zip code for inexpensive bulk rate mailings which may be needed from time to time in mobilizing family support for clients in treatment. Integrity was able to print out 1,000 labels in a matter of 15 minutes and with the help of members these labels were affixed to envelopes and mailing was facilitated which was vital to our funding needs.

9) If an agency is required to use certain numbers to identify clients, these same numbers can be used in the computer system, facilitating state audits of numbers against actual clients. The state of New Jersey still uses CODAP numbers so these are the numbers we have assigned to clients in our computer system.

Integrity operates approximately ten different facilities, some of which do not relate to drug or alcohol treatment. We have identified the facilities by code; for example, our Federal Pyramid halfway house is called PHIF and our Federal Probation is called TCFP while one of our residential TC'S is called TC1A and our Reentry Program is called TC2.

In addition, Integrity has adopted an accounts payable and general ledger system which we have modified slightly to accommodate our specific needs. This system is also appropriate in that it will provide specific profit and loss statements for each one of our facilities as well as a consolidated statement, plus a month by month and year-to-date detailed statement compared to budget figures. This system is extremely straightforward, easy to operated and well-tested. It allows you to spread expenses by a predetermined formula automatically in one step or manually, department by department. Invoices are loaded for payment once and all other necessary entries are done automatically, including posting to the general ledger. JOurnal entries, transferring revenue or accounting for the deposit of money into various departments is also facilitated through this software.

As long as at least one or two staff members are thoroughly familiar with this software, residents or members can do most of the entries and all of the tedious loading and maintaining of the accounts receivable. Integrity has found that a tremendous interest has been kindled on the part of the residents for progressing in the computer operator or programmer field as a result of their experience with our equipment.

Presently, Integrity, in conjunction with Queue Associates, is developing a management system which will focus on the following areas: producing monthly or quarterly reports, including treatment plans and treatment plan reviews; printing dose levels and medication prescription levels for all clients; printing urine labels, printing labels for methadone maintenance clients; printing statistical reports, including CODAP admission and discharge reports and client summaries; projecting the names of all clients with the appropriate updated treatment plan goals; printing the names of all clients with the number of direct counseling hours they have received per month; printing other statistical and demograpahic reports from combinations of any of the fields identified in the data filing software package. In addition, this software will produce personnel reports including staff sick days, vacation days, counseling hours, records of completed staff evaluations, salaries and insurance benefits.

AUTOMATING QUALITY CONTROL: RESIDENTIAL AND OUTPATIENT SETTINGS

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Health Care Delivery Services, Inc.
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This presentation will address quality control and the cost of quality control. The entire health care industry, and especially that part of the industry which receives funding form government sources, has been annually incurring ever increasing administrative costs -- costs that can be attributed in part of demands from funding, licensing, and other oversight agencies for more detailed monitoring of health care delivery systems. Government regulations, insurance requirements and legal safeguards have all forced a great per cent of each treatment dollar to be spent on administration. Correspondingly less can be spent on actual treatment.

Over the last decade, however, solutions have become available which can help reduce the myriad of paperwork associated with administering and monitoring health care programs. The newest advances in computer technology, along with organizational techniques that take full advantage of the power and versatility of the new more affordable person-al and office computers, can provide the therapeutic community and other types of service programs with an effective weapon to stem this rising tide of administrative costs.

System Development

As early as 1976, Health Care Delivery Services, Inc. (HCDS), a parent company for several drug and adolescent treatment programs in the state of California, was applying a computerized management information system that provided clinical management reports on a monthly basis. The system revolved around a series of simple forms that allowed us to automate the client intake process, as well as provide detailed clinical information on each HCDS client during the month. At that time, this sophisticated system of clinical management reports was using relatively expensive mainframe computer time. As of 1981, however, with the availa-bility of relatively inexpensive microcomputers, we converted the system to a microcomputer configuration. We were not only able to maintain the same level of sophistication, but actually found that the microcomputers gave us even more flexibility to format the system for special needs.

Client Population

For the paper presented here, we've focused on our experience with four of our residential adolescent treatment programs situated in both northern and southern California. They range in size from 10 to 70 clients. They include both short term assessment programs (2 to 3 months) that experience a high intake/discharge load (50 to 75% turnover in one month), to relatively long term programs (1 to 2 years) with low client turnover (under 5% per month).

System Design

During the transition from mainframe to micro, we developed two computer based management systems that deal with client tracking and accounts receivable tasks. The Client Data System manages clinical and background information on each client, while the Client Accounting System tracks fiscal data.

Setting and Cost Control System

Client Data System. The client data system initializes at client intake. Background and demographic information is entered into the computer, including birth date, sex, race, source of referral, county or origin, diagnosis at admission, and any other basic information needed on each entering client. Once entered into the computer, this master database becomes a large electronic filing cabinet with a wealth of client information immediately available for agency inquiries, completion of various types of required forms, or other information requests.

This main client database is also the source used for a series of internal reports that help HCDS track client information. A month utilization report provides each director with a census of clients and automatically calculates key statistics (e.g., per cent utilization, etc.) for easy reference. Admission/discharge summaries are also automatically generated each month using this master database and provide information for the director to review the nature of clients entering the exiting the program.

Besides keeping track of background and demographic information, the client data system also monitors clinical activity on individual clients, including tracking individual and group therapy sessions, and client contacts with counselors, medical and other staff. Contacts with others important to the client's situation are also monitored (e.g., welfare workers, probation officers, family, etc.). This information, along with other information important to clinical activities in the program (e.g., rule breaking activity, school behavior, employment activity, etc.) are summarized in a single monthly report. The clinical director is able to review this summary for the entire facility, as well as reviewing information for each individual counselor's caseload.

Client Accounting System

Information on each client that is relevant for billing or accounting purposes is automatically routed into the Client Accounting System from the master database. Time in treatment is calculated based on admission and discharge dates, and monthly billings are printed with time in treatment converted to total actual dollar amounts where appropriate. The accounts receivable billing report for residential claims is broken down by individual counties in the state of California to facilitate individual county billings.

Probably one of the most important components of the accounting system is the time it can save in maintaining individual client ledger cards. Monthly claims are automatically transferred into the accounting system, which provides a separate history of claims on each client. This virtually eliminates the maintenance of individual client ledger cards on each client. Payments are entered on each client's claim, and the individual history for each client calculates total amounts due, while the accounts receivable aging provides a summary (month-by-month) of amounts outstanding.

The number and variety of automatic functions in this accounts receivable system has provided an incredible amount of time savings for tracking monthly billings. The computer can go through a list of client claims and pick out bits of information that once took hours to pull together. With the use of time/motion studies, we found that staff time on just the maintenance of client accounts receivable alone was reduced by over 25%.

Budget Setting and Cost Control System

One of the earliest systems to be automated at HCDS, Inc. was a system to monitor spending patterns. This Cost Control System provides a direct comparison to budget for each expense line item. Comparisons can be made for the current month and for the fiscal year to date. These reports are printed each month as part of our larger general ledger package, and go through a systematic review process every month, along with a more detailed review process every quarter. The entire system has become an invaluable part of our efforts to control spending through the budget setting process.

One of the most important, but most tedious administrative tasks for most treatment directors is the budget setting process. Checking spending patterns from the former year and setting budgets within funding limits can take a great deal of time for executive and support staff alike. For this reason, one of the most valuable enhancements to our cost control system was the development of the Budget Setting System. The budget preparation worksheet is one of the reports generated by this system. It provides each director with average spending on each line during the fiscal year, along with old budget figures and a place to enter the new budget. Printing the budget preparation worksheet is the first step in the budget setting process each year. Once completed, the new budget is entered into the budget setting system, and other report generating features provide complete hard copies of the new budget.

Budget

The maintenance of high quality control standards is a concern for all of us working in providing the public with health care services. While the costs of maintaining quality control systems have been increasing, the newest advances in computer technology have provided a means for increasing the effectiveness of quality control systems without significant increases in costs, and in many cases, with substantial cost savings.

Although we've only had time here today to briefly discuss client tracking and accounts receivable systems, we've had a great deal of success in automating other tasks in various treatment programs. For instance, we have been using an automated and completely integrated accounts payable and general ledger system for some time, providing us with computer check writing capabilities. Also, we recently established a variety of custom systems for maintaining units of service and other types of client tracking for our adult services drug treatment division. Besides our own custom systems, we have been able to automate a number of administrative tasks just using packaged word processing and spreadsheet programs.

Overall, our experience in automating various tasks over the last 9 years has provided us, in all respects, with a much more efficient running organization. But the road has not been an easy one. Choosing the right hardware and software, and the decision to custom design software to fit the requirements for running a health care program have been hard choices to make. We're especially proud of the systems we've been able to develop over the years, and would be glad to respond to any inquiries so that others can learn from our mistakes and successes.

EAP PROGRAMS CAN AND DO WORK IN A TC

Allen Bray

SHAR House,
Detroit, Michigan

The SHAR House Industrial Program is an intensive two-phase, JCAH accredited, drug-free treatment program which was established in 1978 to provide treatment services to the employed substance abuser. The program components include a 45-day residential phase, followed by a six-month to one-year outpatient phase. The employed substance abuser seeking treatment faces limitations regarding the length of treatment due to his job obligations, family obligations, and other related situations. Thus, the traditional TC residential program, which is typically one year or more, is not accessible to the employed substance abuser. The 45-day residential period allows the substance abuser to become involved in an effective approach to treatment without further jeopardizing his job or financial status. It also allows the individual to begin developing the necessary coping skills, self-discipline, and insight to foster a drug-free lifestyle. The residential phase, in conjunction with the outpatient phase, provided the individual is motivated, can lead to long-term recovery from chemical dependence and the subsequent benefits which result from recovery.

Clients take a medical leave from their jobs to enter treatment. The program admits those who are 18 years and older, have a sincere desire to terminate substance use, who have insurance coverage or alternative means to pay for treatment, and who are physically and mentally fit enough to participate in the treatment regimen. Those who have serious medical or psychiatric problems are not accepted into the program. In cases where physical or mental health is questionable, the staff physician and psychologist make the final determination. In cases where medical detoxification is required, the client is referred to an affiliated hospital program for this service. In conjunction with detoxification, the client begins to participate in the treatment process immediately and consequently enters the 45- day residential phase with a higher level of motivation.

Upon admission, the client enters the orientation phase of the program. The client goes through orientation with other residents from other programs. Because these programs coexist within the same facility, this helps to facilitate cohesiveness within the facility. Those in the industrial program are moved through orientation faster to expedite their entry into treatment. While in orientation, those in the industrial program are given individual sessions and attend didactic lectures. This is done to better utilize and intensify their limited time in the residential phase. They are also allowed visits on weekends with family members. The orientation phase generally lasts one to two weeks. Upon the client's demonstration of adequate knowledge of program philosophy, rules and regulations, and house tools, he/she is graduated into treatment.

Once in treatment, the client begins an intensive, highly structured treatment regimen. The client attends one therapy group daily, one or two encounter groups weekly, an individual session at least weekly, a didactic lecture daily, an A.A. or N.A. meeting weekly, and in cases where it is indicated, family therapy with significant others. The program also offers the family association to significant others to help them acquire insight into addiction and supportive techniques. Participation in services is mandatory and takes priority in the daily life of the client. Clients in the industrial program also perform a job function, as do the residents in other programs. However, time spend on job functions is less due to the concentrated services they must attend.

It is important to note that residents in the SHIP Program are subject to the same rules and regulations and TC techniques as the other residents. When not in their groups or individual sessions, they must interact and function within the facility and with the other residents. This approach is effective in that the confrontation and the inherent stresses within the therapeutic community help in the reduction of denial and the minimization of the addiction and its consequences. Also, it assists in the development of coping skills and insights into addiction.

Upon completion of the 45-day residential phase, the resident is discharged and returns to his home and job. At this juncture, he/she enters the outpatient phase of treatment. Group times are schedules to accommodate all work shifts. The client is required to attend twice weekly. Urine samples are taken twice weekly to insure that the client is abstaining from the use of substances. Two positive urine samples and two unexcused absences are grounds for termination from the program. However, some flexibility is needed here. If a client has been progressing and has remained drug-free for an extended period of time, it is in the best interest of the client to allow treatment to continue to help him divert the onset of relapse and active addiction. Typically, clients in the outpatient phase of treatment will have periods of crisis. during these times, outpatient treatment plays an essential role in circumventing the resumption of drug use. Clients in the outpatient phase of treatment are also urged to maintain their attendance at N.A. and/or A.A. This is seen as a vital support system.

It is important to address the role of the employer in the treatment of the employed substance abuser. The employer or someone affiliated with the workplace is frequently the catalyst which initiates the treatment process. This may be a union official, medical personnel, management, or typically an employee assistance representative. The employer can provide invaluable information to treatment personnel regarding the referred client. More importantly, the employer can provide additional support and motivation to the client. As termination from employment is often the primary motivation for seeking treatment, it is recommended that the employer be involved in the treatment process. Visits by the employer during the course of residential treatment are effective in reinforcing the consequences of further substance abuse. Frequent contact with the employer during the outpatient phase is essential and plays a significant role in the effectiveness of treatment. Communication with the employer can alert the treatment personnel to problem behavior on the job which can then be addressed in treatment. Coversely, treatment personnel can appraise the employer of problems with the attendance or drug use, which the employer can then address. This is effective in keeping the client involved in treatment and preventing relapse.

Preliminary review suggests that the 45-day treatment modality is equally effective when compared with long-term treatment. An important contingency, however, is client participation on a regular basis in the 6 to 12 months of outpatient counseling after residential completion.

In light of rapidly dwindling public revenues for substance abuse treatment across the country, service provides with third party potential will better assure their survival by considering this or similar treatment approaches.

WHAT EMPLOYEE ASSISTANCE PROGRAMS EXPECT FROM DRUG PROGRAMS

Larry Levy

Employee Assistance Services,
Novato, California

The four major areas most troublesome for employee assistance programs, TC's and drug/alcohol programs are: a commitment to work together as a therapeutic team, family involvement in the treatment process, individualized treatment for alcoholics and addicts, and aftercare services for the substance abuser and their families.

Commitment is needed for both the employee assistance program and the drug/alcohol program to work together as a therapeutic team. The major problem areas are: often dissension rivalry and jealousy; roles are not clearly defined; mutual distrust as to client's needs; confidentiality violated; and E.A.P. attempts to provide treatment, thus conflicting with TC objectives.

The Employee Assistance Program's Responsibilities

1. Consult and strategize with the manager faced with a nonproductive and troubled employee.
2. Define personnel policy and disciplinary alternatives.
3. Conduct an intervention on the job with the focus on job performance issues.
4. Evaluate client's problems and motivate him toward treatment.
5. Refer client to an appropriate facility, program or therapist.
6. Provide intake counselor with background information.
7. Verify insurance coverage.
8. Arrange for medical leave of absence, sick leave or short term disability.
9. Adhere to TC's admission procedure.
10. Contact and involve family in the treatment process.
11. Monitor client's progress, attendance, motivation and participation in treatment.
12. Participate in TC staff meetings.
13. Attend and participate in "back-to-work" conference.
14. Provide input into discharge and aftercare planning for both client and family.
15. Provide limited and general feedback to management, while ensuring client confidentiality.
16. Once client has returned to work, monitor job performance and aftercare attendance.
17. Receive copies of discharge summary and aftercare plan.
18. Resolve problems with insurance coverage and treatment costs.

The Employee Assistance Program's Expectations

1. Expeditious and reasonable admission process.
2. E.A.P. background information valued and disseminated.
3. Immediate notification of client's admission.
4. Provide weekly progress reports.
5. Contact family and arrange for an individual interview.
6. Welcome E.A.P. participation in treatment planning and attendance in staff meetings.
7. Provide written discharge summaries and aftercare plans.

8. Specifically define and respect E.A.P. role.

9. Work toward the common goal of helping clients.

Family Involvement

Most E.A.P.'s acknowledge addiction as a family disease and that the entire family must be treated. The E.A.P. should have already contacted the family and encouraged their participation before the client is admitted to the TC.

Problem areas include: some programs delay contacting the family; some programs either ignore families or handle them in a token fashion; often the family is simply referred to Alanon or Narcanon; no attempt is made to meet with the family alone to assess their needs and encourage treatment. Quality programs provide "family education series" which include films, lectures, individual and group counseling; some programs have families spend a full week at the program.

The E.A.P. expects the TC to have immediate contact with the family upon the client's admission, to provide an individual interview with the family and to develop a separate and individualized program for all family members. In addition, the TC should provide referrals to appropriate self-help groups, provide a comprehensive program of counseling and information at least three nights each week, consideration of an outside referral for longer term marital or family therapy, inclusion of the family in a strong aftercare program, periodic feedback to the referring E.A.P. and conjoint sessions while the alcoholic/addict is in treatment.

Individualized Treatment for the Alcoholic and Addict

Most E.A.P.'s recognize the individualized needs of clients and expect that TC's provide individualized treatment. Most programs boast about individualized treatment but fail to provide it because of lack of qualified staff or funds. Group therapy is most effective with addicts, but it does not negate the need for individual treatment.

Problem areas include: often individualized treatment consists of a 15 minute counseling session with the assigned counselor; individualized needs are often ignored, shelved or handled peripherally; some programs are content to move cents through steps 1 through 5 of Alcoholics Anonymous; often only the most disruptive and pathological receive special attention.

Aftercare

In my opinion, the most important part of treatment is aftercare, yet it is given the least amount of attention by treatment staffs. This is the toughest time for clients who are trying to adjust to the real world without chemicals. The standard format is usually weekly "rap" groups at the facility and recommendations to attend a lot of NA and AA meetings. Often aftercare is viewed as an "appendage" to treatment. Attendance in weekly groups usually tapers off after 3 months, but staying clean and sober is a lifelong process.

The E.A.P. expects individually tailored aftercare programs for both client and family. Aftercare planning should begin at the onset of treatment and then refined throughout treatment. The E.A.P. should participate during aftercare planning. The aftercare plan should include references to outside clinical activities, and progress and attendance in aftercare needs to be reported to the Employee Assistance Program.

ENTERPRISE IN THE NON-PROFIT ZONE

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This presentation suggests a few of the many organizational structures available to those non-profit organizations considering business ventures. The details of any proposed structural and functional relationship are highly technical and should benefit from the advice of a learned legal counsel. This presenter is neither an attorney nor an accountant, but rather an enterprising human service advocate. This presentation is made in the hope of generating some thoughtful consideration of the issue and eliciting helpful suggestions.

Before discussing alternate corporate structures, we should consider why they may be needed or desirable. A corporation should not reorganize because everyone else is doing so, or because it simply feels like it. The process should be careful and deliberate. One should consider the nature and relationship of the organization's current and planned activities. Are they similar? Is one an outgrowth of the other? Is one meant to generate money for the other? The answers to all these questions can be yes and still not warrant alternative structures.

The primary consideration in any corporate reorganization of a non-profit service agency should be to protect and nurture the original organization. Thus, some functional objectives of restructuring can be to shield the assets of an operating service provider from litigation or other liability, to properly position the organization's rates in a regulatory environment, to enable the advent of different and possibly revenue generating activities, and to generate funds for non-reimbursable activities such as research and advocacy.

An important consideration is the present tax exempt status of the operating agency and protecting it from revocation. The one tax that all non-profits are liable for is the tax on unrelated business income. There are three conditions that an activity must meet in order to be deemed unrelated and therefore taxable.

The first test is being a "trade or business." Quite simply this means an activity that produces an income generated by provision of a service or product. In this test, the nature of the product and/or service is not considered. The second test is a determination that the activity is "regularly carried on." This is determined by the frequency, continuity, and comparability of the activity. The latter is a comparison to the manner in which proprietary organizations engaged in a similar business or trade conduct the activity. The third test determines whether the activity is "substantially unrelated" to the operating organization's tax exempt activity. The purpose to which revenue is put is not considered in this test, only the actual nature of the new and original activities.

Some organizations conducting unrelated activities may choose to keep them in-house. There is no clear cut rule used by the IRS as to how much unrelated income will jeopardize current tax exempt status. A general rule of thumb generated by some IRS "scholars" is 16% or less of unrelated income may be garnered without risking tax exempt status. This is not a concrete rule and different IRS regions can render different rulings. There are other reasons to avoid additional corporations. They may be too burdensome administratively. Several activities under one corporate roof may allow offsetting the profits of one with losses of another, thus remaining under the 16% threshold.

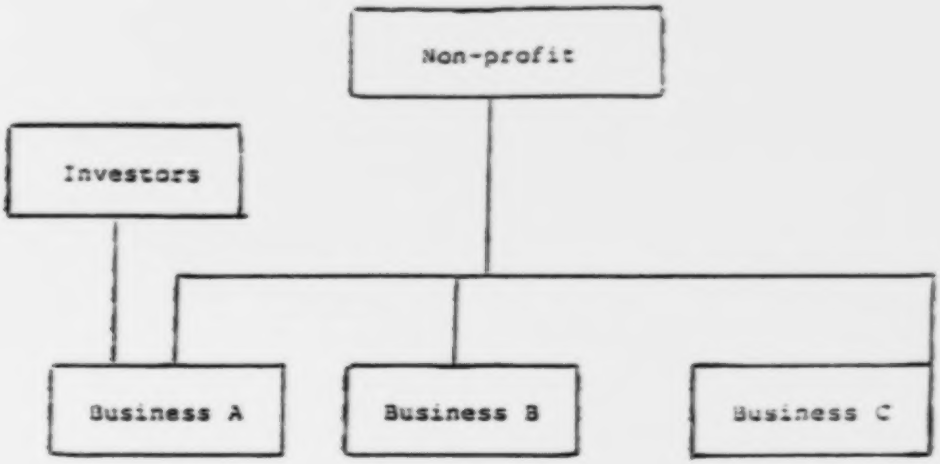
This presentation, however, is premised on the assumption that a tax exempt organization, after careful consideration, has determined to spin off a business activity. There are several matters that must be considered in structuring the new corporation and relating it to the original. Dominant among these is whether money is to flow from the business to the tax exempt corporations, the degree of relatedness of the organizations, and the actual form of the new entity.

The latter may be profit making or non-profit, a trust, a corporation, a cooperative, or an unincorporated entity. The issue of proclaiming a corporation as a for-profit is ironic in that neither law nor IRS codes require such a corporation to be profitable or even to intend to make a profit.

Money flow and direction must be planned for. The new business entity may pay for or collect fees such as rental of space, equipment, and personnel. If stock is issued by the profit making business, the non-profit may receive cash in the form of dividends. The latter is considered passive income and is less likely to jeopardize tax exempt status.

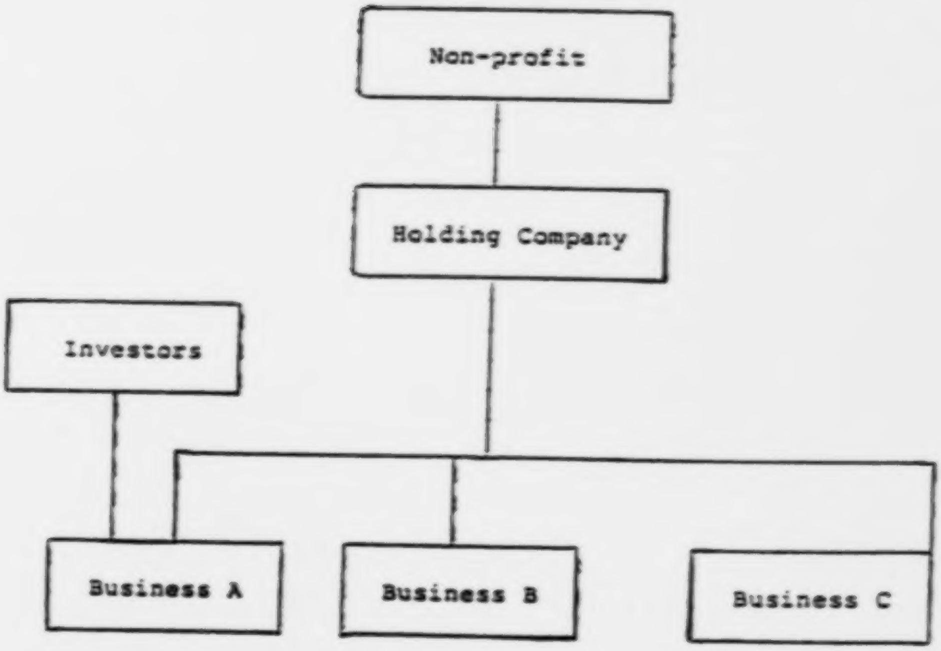
The new entity may be totally controlled by or independent from the non-profit. Such control issues are managed through stock ownership, by-laws, and membership criteria in the corporations, and interlocking directors. A usual consideration is the prevention of external entities from piercing the corporate veil.

Figure 1



Structure A

Figure 2



Structure B

Let us now examine a few potential structures and briefly discuss their strengths and weaknesses. A structure that may be the simplest includes the non-profit as a parent or umbrella corporation with one or more proprietary subsidiaries. The latter may be wholly or partially owned by the parent (See figure 1).

In business venture A, the parent may own some or a majority of the stock. In B and C it clearly is the sole owner of the stock. Some of the advantages of this structure are that the non-profit can continue to garner governmental assistance and be attractive to some donors for tax purposes. A disastrous business venture by one of the corporations would not jeopardize the assets of a more successful one because they are housed separately. A major disadvantage is that the parent can not pool the losses of one with the earnings of another to minimize the tax liability of the profitable one. This can, however, be done by a parent that is for profit and therefore subject to taxation.

To overcome the disadvantage noted above, a for-profit holding company is often inserted between the parent non-profit and the business ventures. Thus, by owning all of the stock of the holding company, the non-profit can have its holding company subsidiary pool losses and earnings to minimize its tax expense (See Figure 2).

Two structures that may be used to deal with rate setting and asset preservation concerns are referred to as the sibling and parent-child reorganizations. The former is more effective in preventing the piercing of the corporate veil, but requires a greater leap of faith. That is, in the sibling structure, one corporation gifts all of its physical and cash assets to a sister or brother corporation which is trusted to use these assets for its own and its brother or sister corporation's benefit. The disadvantage of this structure is that there are no assurances that the gifted assets will be used as intended, hence the "leap of faith."

The parent-child model allows for more direct interaction between the corporations through membership criteria, but is more susceptible to having its veil pierced. In this structure, a newly created parent corporation can receive all of the assets and become the sole member of the child corporation. This can assure that the parent votes in the board of directors of the child, thus assuring that the assets and operations are used in tandem, although at arm's length.

In any reorganization, several factors must be carefully considered. The choice of structure may depend on any combination of local politics, administrative efficiency, desired path of capital flow, possible funding sources, local laws, and of course, federal tax considerations. In some instances, a community may be opposed to certain services being provided by a profit making company. An example may be the new phenomenon of prisons for profit for adults and adolescents. In addition to the usual opposition to the establishment of such a facility in any community or neighborhood, the opponents may decry the profit motive in incarcerating people.

In another community, local garages and service stations may be up in arms over a competing business established by a therapeutic community. TCs have access to a "cheap" labor pool and, if set up as a non-profit, tax exempt status. This enables undercutting the competitor's prices and making up the difference through volume and the non-payment of taxes. Another consideration may be the limited scope of political and lobbying activity that can be carried on by a tax exempt organization. A proprietary corporation has virtually no limits on its electoral and/or legislative involvement.

The concluding thought in this presentation is to proceed cautiously with good expert advice. The first crucial decision is programmatic because it determines whether an organization wishes to diversify its services and/or products. This can be done by the board, staff, and clients of the organization. The next two decisions warrant expert external counsel. These crucial decisions are whether reorganization is necessary, and if so, what form it should take.

TC OR TLC: AN IDENTITY CRISIS

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It is helpful, when evaluating the ideas presented in a discussion about drug abuse treatment, to understand a little bit about the background of the presenters.

Brewster, a social worker, began his drug abuse treatment career in 1968, in the first public treatment program in California to offer both inpatient methadone detoxification and a therapeutic community, The Mendocino State Hospital Drug Program. Closed in 1972 by then Governor Reagan, "The Mendocino Family" was the forerunner, essentially the progenitor, for the many therapeutic communities historically and currently operating in the Western United States: The Napa Family, Arizona Family, Camarillo State Hospital Family, Metropolitan State Hospital Family, Tarzana Family, "Our Family" (Imola, California), Portland VA Family, Texas Family, Ayrie TC (Denver VA), Peer-I Family (Denver, Colorado). Leave it to say that the residuals of Mendocino continue, having evolved with the times, but characterized by the same basic tenants that produced its original success and influence.

I (Brewster) have remained in the substance abuse treatment field and currently hold a faculty position as a senior instructor with the School of Medicine, University of Colorado, and serve as the associate director of the Addiction Research and Treatment Services, University of Colorado Health Sciences Center (hereafter referred to as ARTS).

Mr. Jaramillo became interested in drug abuse treatment in 1972, while serving a 26 year sentence at the New Mexico State Penitentiary as the result of heroin addiction. As an inmate, he helped to develop the penitentiary pre-release program which incorporated ideas and methodology from TCs such as Synanon and Delancy Street. He ultimately became director of that program and was subsequently released from prison in 1975.

Following his release from prison, Mr. Jaramillo relapsed, leading to his admission to the Peer-I Therapeutic Community. Graduating in 1980, he sought employment as a counselor, leading to his current role as clinical coordinator. Mr. Jaramillo has been drug free for 7 years.

Before beginning, we would like to briefly describe our program: ARTS has 87 residential beds; Synergy, a 26 bed long-term adolescent substance abuse treatment program; and Peer-I, a 61 bed therapeutic community, the program providing the basis for our presentation.

ARTS' Outpatient Clinic offers multimodal treatment approaches, including methadone maintenance treatment for 150 clients, a Naltrexone Clinic, and array of specialty clinics consisting of a Cocaine Clinic, Halsted Clinic (treating impaired health professionals), Family Intervention Program, a Professional Athletes Clinic, and a Criminal Justice Clinic. We treat approximately 300 clients in the Outpatient Clinic. ARTS also provides medical and community education, along with conducting a variety of research projects, with a current focus on tobacco dependence, cocaine treatment, and the etiology of alcoholism (studying primate colonies).

The title of this presentation, "TC or TLC: An Identity Crisis," will focus on our attempt to demonstrate that TCs nationally are in a state of transition which, in our opinion, is leading to the possible disintegration of the entire TC movement in the United States. And what a movement it has been! Beginning in 1958 with the development of Synanon, the therapeutic community raced across the United States, becoming the primary form of drug-free treatment employed in most urban areas. Its brash, unapologetic style, while offensive to some, provided treatment for the first time to the heretofore "untreatable" drug abuser. For the first time in psychiatric history a clinical approach, spiteful of Freud and his "henchmen" for their historical discrimination and diagnostic insults, began to modify a specific typology of drug abuser, the "hard core," criminally involved, chronic addict. Not only did the TC invite the most unattractive clients, it engendered their respect and was able to offer a responsible life style that did not incorporate drugs, prostitution, violence, deceit and the whole lineage of despicable behavioral characteristics represented in the drug abuser's universe.

Mr. Jaramillo and I represent what some might call the "old school" in regard to what a TC is, and ought to be. In fact, it is our strong belief in the basic tenets of traditional TC methodologies that prompted us to submit this paper. Over the past few years we have been struck by what appears to be a significant change in the types of treatment programs calling themselves TCs. In fact, the term appears to be losing its meaning.

Where once a TC was universally defined as a lengthy (minimum of a year), strongly confrontational, "self-help" program run by clients, monitored by staff (who were usually recovering drug abusers), characterized by harsh motivational testing, discipline, initiations (puberty rites), where everything was done compulsively (or else), we have begun to see the emergence of short term (60 to 90 days), non-confrontational programs, operated by credentialed mental health professionals (social workers, psychologists and the like), who have entered the TC movement via the educational rather than the experiential route.

What we are seeing is alarming: 1) a trend toward treating the "soft core," employed, insurance carrying client as opposed to that "hard core," disenfranchised, criminally oriented "reject" that TCs were created for; 2) a re-emergence of mental health ideologies and criteria defining this form, as well as other forms, of drug abuse treatment--a trend which appears to be influencing the substance abuse field in general and which has many dangerous implications, not the least of which is a dramatic reduction in the length of stay and the loss of confrontational behavioral treatment techniques; and 3) possibly the most alarming trend, the loss of the recovering abusers influence and point of view. This appears to be true of both recovering alcoholics and drug abusers.

In Colorado, for example, the tremendous growth of proprietary hospitals for the treatment of alcohol and drug dependency has virtually removed the recovering population from a position of influence. It's now profit margin, census, EAP hustles, advertising, competition... It's dollars, folks! The recovering people have been so successful, particularly in the alcohol field, that they have worked themselves into a dilemma. Although I'm sorry to say it, most of the influential recovering people no longer work with the primary commitment of "saving lives," they work instead for a corporation, for money and corporate growth.

This phenomenon is also happening in the drug abuse field. It is happening to the TC movement, and it is possibly the most serious assault on our sovereignty that we have ever faced. Yes, even more serious than reduced funding. And isn't it ironic that, in order for the TC to survive fiscal cutbacks by changing its length of stay, composition, and client type, we have become vulnerable to extinction. Because it appears that what we're doing is trying to attract the less severe, insurance carrying drug abuser and fitting them into a short-term program, just like our alcoholism treatment colleagues are doing. You might argue, so what? It's OK to have money and power; hell, it's American. Yes, money and power are fine goals, but not as primary motivators in human services. Our integrity can be corrupted too easily by them, and besides, have we forgotten that the TC client doesn't carry insurance or have much legally attained money? The TC client is a criminal! The TC client has no alternative except the most intensive forms of psychological interventions. If there is an effective, short-term drug-free alternative that can fit the TC eligible client, the field should adopt it immediately. But we don't think that such an approach exists.

TCA Survey

Because we thought that there was the possibility of a changing character in the therapeutic community movement, we decided to conduct an informal survey, or poll, of TCs across the country. We selected the programs to be surveyed from the TCA letterhead because TCA is the national organization representing therapeutic communities throughout the nation. All programs on the letterhead were called, totaling 50.

The survey took place during the weeks between July 10 and July 25, 1985. All of the interviews were conducted by telephone, and all respondents identified themselves as staff members of the program, ranging from intake coordinators and counselors to directors and executive directors.

Of the 50 programs called, 21 (42%) responded to the questions. Although there were a variety of reasons given for refusing to respond, the primary ones were because of program confidentiality or a lack of administrative authorization. Table 1 shows the questions asked, with aggregate program responses.

Discussion

When discussing the findings of the poll, it should be kept in mind that this was a very limited effort and is being used here because it tends to support certain of the authors' observations about changing trends in the TC movement.

Responses to the survey point toward the possibility that TCs are indeed changing. Programs are more and more using mental health professionals as executive officers, where historically recovering abusers were responsible for clinical and administrative activities. Although the breakdown was close (52% non-recovering, 48% recovering), the change is dramatic and will have a significant impact on the clinical operations of TCs. This is not to suggest that the changes will necessarily be negative. Mental health professionals have a great deal to offer the TC. Our concern is focused on the possibility that with a change in the type of clinical/administrative leadership, ideological differences may intrude on the management of the TC. These changes then may cause programs to swing widely from their historic concentration on the client's unique treatment needs and unusual clinical interventions toward looking for ways to produce revenue and shorten stay, possibly at the expense of the client.

To continue, some of the speculated changes may already be occurring. The use of confrontation/discipline based behavior shaping techniques (signs, verbal aggression, costumes, etc.) are utilized very infrequently in the programs we sampled: 17 programs (81%) of the respondents reported the absence of such techniques, with only 4 (19%) indicating that they were still in use.

Intensity of treatment also appears to have changed, with a low to moderate intensity characterizing 14 (67%) of the respondents. Seven programs (33%) described their intensity as "hard core." Although we left the definition of "hard core," moderate, or "soft core" to the respondent, the results still appear to have a relationship with our hypothesis. It is our strong belief that only the "hard core" substance abuser is a candidate for a TC and that practically all others can be treated effectively as outpatients, or with minimal residential treatment.

A pleasant finding involved the responses to the question about the use of confrontation groups. The majority of programs, 16 (79%), reported using "games", encounters or other forms of confrontation groups as a basic part of their treatment. Because confrontation is considered basic to all TCs, we were pleased at this finding, although it left 5 programs (21%) reporting no use of group at all. Another possible warning of decay?

Based on the above findings, it is our contention that therapeutic communities are changing their structures and subsequently losing their identities, possibly as a result of the movement's need to survive. Specifically, we have postulated 5 influences leading to the changes.

1) The most important influence is the advent of private health insurance coverage for alcoholism and drug dependency treatment services with strict provisions covering maximum length of stay, e.g., 21 to 45 days.

2) Third party payment has led to profiteering, at times without regard to clinical efficacy.

3) With shortened treatment episodes and the reduction of "hard core" clients, there is a significant decrease in the use of aggressive behavioral techniques such as verbal and visual disciplines, confrontation groups, etc.

4) The public's (Congress') apparent disinterest in clinical activities, while at the same time concentrating on drug prevention, led to massive cuts in treatment funds for indigent drug abusers.

5) The recovering abuser's leadership has been supplanted by the mental health professional.

With the onslaught of hospital based, profit oriented substance abuse treatment programs, the therapeutic community may be in danger of extinction. Why? Because TCs are deemed appropriate for only about 10% of the total client pool. It is our contention that the vast majority of the remaining drug abuse population can be effectively treated as outpatients, without the need for more restrictive, not to mention expensive, inpatient (residential) treatment. If the trend toward short term "softer" TCs continues, it would seem logical that funding sources, particularly government agencies, might begin to compare the programs, which may lead them to the false conclusion that you can do in 30 days what the traditional TC has taken 12 to 24 months to produce.

To argue that short term residential (inpatient) treatment is the most effective modality for substance abusers is fraught with problems. Alcoholism outcome research has clearly stated that, for the most part, several weeks of inpatient treatment has about the same outcome at one year as outpatient counseling only. Although drug treatment outcome research is in its infancy, what studies have been done tend to support the idea that length of stay is the most significant predictor of success--the longer stay correlating with the better outcomes. So it would appear to be a mistake for us to support the increasing ambiguity about what constitutes a therapeutic community. A short term, middle class residential drug program is simply not a TC!

Philosophical Metamorphosis

Although we believe that it is the introduction of insurance payments and reduction of public funding that are chiefly responsible for the identity crisis, there is also a change in clinical philosophy that requires discussion.

Freudenberger, a significant influence in our field and brilliant in regard to many of his concepts on burnout, made comments that the mystique and romanticism had gone out of the ways we were treating drug addicts. We will paraphrase certain of Freudenberger's ideas because they tend to illustrate what we believe are increasingly the thoughts of many contemporary TC leaders and are, in part, responsible for our burgeoning identity crisis.

Freudenberger, suggesting that therapeutic communities should shorten treatment, stated, "These realities (limited funding and loss of mystique) do not allow us the luxury of 2 and 3 year residential treatment programs." He negated the use of the "encounter" (for our East Coast friends) or "game," (for us Synanon products), making the statement that, "the residents have become sophisticated defensive, conning, manipulative and evasive techniques so they can survive encounter without being changed by it."

First, his poor understanding of the use of confrontation groups is clear because of course we all know that the "encounter/game" has many purposes, the least of which is to cure a drug addict. Among other things, it allows for a large group of aggressive deviants to live in the same environment without killing each other. It's also a management tool, allowing client operated treatment systems to communicate hierarchically and with staff.

Further, he postulated that there are no longer hard core addicts around. Well, if he (and we) don't consider characteristics such as conning, manipulation, evasive techniques as "hard core" traits, we had better start all over. If the "hard core" addict has disappeared, where have they gone? At Peer-I we've got lots of them. Of course, we now define them differently than we did 10 years ago, but it's a joke to believe that there are no longer hard core drug abusers. Hell, they're probably harder core now than they were. Younger, yes. Poly-drug, most certainly. More sophisticated pharmacologically, absolutely! Soft core? No way.

So, Freudenberger has suggested shortening the length of stay and doing away with the confrontation groups (encounter/game), adding that we should, "...teach the rudiments of proper diet, of cleanliness, of the basic economic facts, of vocational skills, of everyday living routines, of personal grooming and dressing, and most important, of forming an accurate self-concept." And accomplish all of these, as he postulates, in a short term program. He suggests, "We need to get out of our we must produce successful graduates bags." Wow! That's about as close to heresy as you can get. Don't we all know that it is the enthusiasm and commitment of producing the successful graduate that is essential for the remarkable and impressive successes of the many TCs throughout the country? I would guess that many of you listening to this presentation are products of just such evangelism.

Sure, we shouldn't be deceitful; clients aren't "widjets" to be mass produced. But the major reason TCs have been so strict in relation to success criteria and the clinical process is that compromise with the clientele we were designed to treat is suicide. That's where rigidity came from. And believe it, most mental health professionals are not trained with the type of consistent, strict ideological adherence required to operate a TC correctly. Only the behaviorists have the type of orientation that is required, and most of them are not comfortable with the need for aggressive surveillance and the associated demands required in the maze of the TC matrix.

We believe that it is the Freudenberger naivete that is characteristic of the non-recovering mental health professional, which is therefore likely to seriously contaminate the TCs identity and quite possibly the lives of many drug abusers. That's the Tender, Loving, Care most of us don't need to change our lives.

So, you ask, what model of TC do you believe in? Are you as provincial as you sound? Well, yes...and no. We believe that TCs, like good football teams, should handle the basics before they try the fancy stuff. We define the basics as follows:

1) Admission criteria to the TC modality should be for a drug abusing population requiring the most intensive and restrictive treatment--the chronic, severe (hard core), personality disordered, usually criminally involved, substance abuser. Less severe, and otherwise disinterested clients, should be treated in different, less restrictive environments, e.g., outpatient, short-term residential, methadone maintenance. You don't admit people to TCs unless they clearly need to be there! We speculate that 80% to 90% of al drug abusers can be treated effectively in outpatient settings. So you see, we are actually opposed to inpatient, or residential, care except in those unusual cases requiring it.

2) Control over all admissions and discharges. Voluntary versus involuntary is essentially a moot issue since it is clear that nobody has been able to define the difference. Whether Aunt Tilly threatens to revoke your inheritance or a superior court judge says, "50 years or the TC," makes no difference. One way or the other, you're in. And, of course, we are all becoming increasingly aware that the more involuntary one is the better they do--a simple tenet of contingency management therapy. The important factor is that the client has an alternative to treatment, e.g., the streets, jail, work.

3) A treatment program which provides a drug free extended family, where his/her developmental processes can begin anew in a strict system of balanced positive and negative reinforcers. Day to day living should be rigorous and confrontational, well supervised, with a hierarchical system of non-token client government participants serving as role models, teachers, and parents to the younger residents.

The treatment should be safe, involving confrontations and discipline, along with reward systems. It is an important treatment goal to get the client's absolute commitment to change his/her life. This commitment usually takes several months to occur, but is essential in order for the client to begin change in earnest. status, discipline, identification, confrontation, and self-help are several of the hallmarks of TC treatment. The program should be characterized as highly responsible, with the goal of perfection, and the realism of human error. Length of treatment for the appropriate client should be, at minimum, 9 months to one year, followed by a re-entry period of 6 months to a year.

4) Staffing in a TC should consist primarily of recovering, credentialed therapists, supplemented by non-recovering experts in administration (who ways an ex-addict knows how to run a business?), and psychologically sophisticated professionals who function as consultants, e.g., psychologists, social workers, counselors. We feel that went you remove the dedication, zeal, and knowledge of the recovering abuser from

clinical leadership, you no longer have a TC. Instead, you have another form of intensive residential treatment program for substance abusers.

Conclusion

In summary, the TC program should teach a client how to live as a responsible and drug-free member of their community. This is brought about by treatment that provides a consistent (strictly controlled), drug-free, long-term treatment environment, teaching the client via continuous feedback to heighten self-awareness and produce a positive identity while stripping his/her character defenses and reducing impulsivity. Specific interventions, modalities if you will (affective, cognitive, behavioral), should always be offered, adding and deleting modalities as evidenced by the needs of the population in treatment and as pragmatic issues dictate. But we cannot stop discipline, confrontation, and the system of idealistic extremes, for without these our clients, bless their little hearts, will not get better. In fact, their disease will simply, and secretly, be acted out in treatment rather than on the streets. A re-entry period of 6 months to one year must follow the intensive TC experience. The focus of re-entry must be reintegration and the establishment of a social support and financial system.

We are also warning the therapeutic community field that we may be losing our most important resources--the recovering substance abuser. We don't want to revert to what once was--a system of treatment which had no idea what the TC candidate was all about, a system that consisted of dedicated but naive practitioners whose commitment was to their job, not the changing of human conditions. Synanon was born of this benign neglect.

Let's not bring about a complete 360 degree return to the past. We would suggest that the field should strictly define a therapeutic community so that it doesn't simply disappear. We don't oppose the traditional mental and medical professionals having a piece of the action. Hell, they're offering great advances in differential 5approaches to substance abuse. We simply want the TC to remain for whom it was originally intended and for whom it has worked so effectively. We are not here to argue why change may or may not be necessary, since change does and will continue to occur. That the drug abusing population is changing is true, but that fact alone is not sufficient reason to do away with effective treatment principles.

Let us not forget what we teach our members, "Don't forget where you came from!" While others compete for the recently identified substance abuse dollar, let's not lose our sense of what we know is necessary in order to produce truly healthy ex-addicts. Let's not compromise our values and philosophies or, in the process, we not only lose the sense of our mission but also, and saddest of all, our clients failures might become the by-product of our greed.

7

TABLE 1

QUESTION	RESPONSE	
1.What is your role in the TC?	Administrative . . .	8(38%)
	Counseling Staff . .	13(62%)
2.Are you recovering?	Recovering	13(62%)
	Non-recovering . . .	8(38%)
3.Describe your program's discipline(verbal aggression signs, costumes)	External discipline (signs,verbal attack)	4(19%)
	Other(non-visible)	17(81%)
4.Does your program use confrontation group therapy?	Yes	15(71%)
	No	6(29%)
5.Are you a "hard-core", moderate, or soft-core program?	Hard-core	7(33%)
	Moderate	10(48%)
	Soft-core	4(19%)
6.Are you professionally run, or recovering run?	Professional	11(52%)
	Recovering	10(48%)
7.What is your estimate of indigents vs. paying clients in your program.	Indigent	--(78%)
	Paying	--(22%)
8.What is your estimate of referrals from:EAP,criminal justice, or other(self,etc.)	EAP	--(5%)
	Criminal Justice . . .	--(55%)
	Other	--(40%)

THE PARA-PROFESSIONAL VS. THE PROFESSIONAL: BREAKING THE BARRIER

Logan Lewis

A.P.P.L.E.
New York, NY

The conflict between the program graduate counselor and the M.S. or M.S.W. counselor is as old as the therapeutic community. Some of the basis of this conflict stems from the disparities in education and life experience of the two groups.

Social work training for clinical practice or intervention is not geared toward substance abuse treatment within a therapeutic community. The social worker, while valuing clinical techniques and approaches, is not trained to understand or value the therapeutic community concept. The social worker, newly entering a therapeutic community, is basically entering a foreign environment, one in which they do not understand much of the language nor much of what is happening. Many therapeutic community techniques seem contrary to good social work practices, i.e. loss of privileges, contracts, sanctions, etc. In addition, often the new M.S.W. has little respect for the program graduate counselor, considering him or her to be street wise, undereducated and overly glib.

In return, the program graduate counselor often has even less respect for the M.S.W. The substance abuse counselor maintains that "book learning only goes so far" and often views the M.S.W. as an inexperienced "bleeding heart" who has little understanding of drug addicts and is easily manipulated.

The substance abuse counselor is a graduate of the program. Thus, he/she has experienced personal growth and change within the therapeutic community and has a strong belief in therapeutic community concepts and therapeutic community methods. In addition, the substance abuse counselors, because they feel a part of the system, control the system.

The result, as experienced at Apple, was two groups of counselors with separate belief systems, with little respect for one another, but with one common goal--to help and assist the client to overcome the drug problem. The conflict, however, worked to the disadvantage of the clients and undermined the effectiveness of the therapeutic community, establishing camps that worked in opposition to one another.

In attempting to overcome this seemingly inherent conflict, Apple developed a treatment staff training program backed up by administrative policy which clearly defines the program's approach toward treatment.

The basic tool used to break down the barriers is the Substance Abuse Counselor Certification Manual of T.C.A. This manual was compiled under the leadership of David H. Kerr, Chairman of T.C.A. Credentialing and Accredition Task Force. The drive for credentialing was initially motivated in part, to establish a professional credential for the program graduate counselor. At Apple, however, it is a very useful tool in teaching therapeutic community concepts and techniques to the M.S. or M.S.W. counselor and promoting staff cohesiveness.

All treatment staff are required to become T.C.A. certified within two years in order to maintain employment. Directors must take the lead. Therefore, the Clinical Director, a certified psychologist, and the Program Director, a program graduate, have both become T.C.A. certified. Both directors are responsible for the "treatment staff" training sessions, bringing the substance abuse counselors and social workers into a discussion of unifying treatment concepts.

The competences developed in the T.C.A. manual are easily related to the M.S.W. educational background and the substance abuse counselors life experiences, allowing each to participate in the training as a trainer. For example, *Competence 1* is "Understanding and promoting self help and mutual help." Even though they may not recognize it, the substance abuse counselors and the social workers have learned in their training to work with the client without telling the client exactly how to solve his or her problem. Each has learned in their training to encourage the client to solve problems by themselves, stressing use of the tools of the environment As we begin to use this Competence in the staff training, we encourage both the social worker and the substance abuse counselor to discuss from their own backgrounds the means of implementing this Competence, of getting the client to help himself or encouraging the client to seek help from others.

Competence 3 is "Understanding of social learning versus didactic learning." Although many of the substance abuse counselors may not know the definition of didactic learning, both the social worker and the substance abuse counselors have learned about the natural process of growing up and maturing, of allowing people to interact with others, to express feelings, to be able to show frustration, even to be angry. The discussion of social learning versus didactic learning and their use at various times during the treatment process allows the substance abuse counselors to speak on the benefits of both social learning and didactic learning in the treatment process This enables both counselors to recognize that they may have learned to achieve the same goals from different roads; it enhances respect for each other, breaks down the barriers, and builds support.